Austin Health

OBESITY CLINIC REFERRAL FORM

Email: - outpat231@austin.org.au Telephone: (03) 9496 2900 Fax: (03) 9496 2097

REFERRING DOCTOR:	**CLIENT DETAILS:**
Dr Address: Phone: Fax: Provider No: Email: Signature: **DATE OF REFERRAL:** Referral valid for:	Name: Address: Male/Female Phone: Home: Mobile: Date of Birth: Medicare No: ☐ Interpreter required? (language_____)

UNIT REQUIRED: Obesity (medical) **Head of unit: Prof J Proietto**

Clinical details: (all parts of this section must be completed)

Height: _____m; Weight: _____kg; BMI: _____kg/m^2 waist circumference: _____cm

Complications:

☐ T2DM (if yes, HbA1c_____, date_____)
☐ Hypertension
☐ Hyperlipidemia
☐ Coronary artery disease
☐ Cerebrovascular disease
☐ Peripheral vascular disease
☐ Musculoskeletal
☐ Impaired fasting glucose/impaired glucose tolerance
☐ Obstructive sleep apnoea
☐ Osteoarthritis
☐ Polycystic ovary syndrome
☐ Fatty liver disease
☐ Mental illness (specify_____)
☐ Other (specify)_____

Medications

Other relevant information