Patient Details

Name: _____

Date of birth: _____ Phone: _____

Referred to: _____

Referring Clinician

Name: _____

Practice: _____

Reason for referral (please tick)

- ☐ Obesity management
  - ☐ Adult
  - ☐ Adolescent (aged 14 or older)
- ☐ Metabolic health assessment
- ☐ Perioperative optimisation
- ☐ Preparation for bariatric surgery (pre and post-operative)
- ☐ Lap-Band adjustment/management
- ☐ Body composition analysis
- ☐ General lifestyle consultation services
- ☐ Other: _____

Relevant clinical background

_____

_____

_____

_____

Current medications (if relevant)

_____

_____

_____

_____

re:you

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health beyond weight