

Surgical Weight Loss Centre

Fax: 905 275 1582

www.swlc.ca

REFERRAL FOR CONSULTATION

Lap-Band Program

Gastric Balloon Program

Referring Physician: _____

Physician Address: _____

Patient's Name: _____ Gender: _____

Date of Birth: _____ Height: _____ Weight: _____

Address: _____ BMI: _____

_____ Health Card #: _____

_____ Phone#: _____

Reasons for Referral:

Significant Medical History:

Referring Physician's Signature:

Date:



Canada's Leading Weight Loss Clinic
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