Barrie Community Health Centre

My Best Weight Program

Barrie Community Health Centre
www.connectbchc.ca

REFERRAL FORM
Phone: 705-734-9690 ext. 283
Fax: 705-719-4877
490 Huronia Rd, Barrie, ON, L4N 6M2

Please note, referral ***must*** *be accompanied by each of the following to be accepted into the program:*

- *Complete medical history*
- *Active medication list*
- *Recent labwork (A1c, egfr, sTSH, lipid profile)*
- *Completed Client History Questionnaire*

PATIENT IDENTIFICATION – CLIENT MUST RESIDE IN CATCHMENT AREA (POSTAL CODES L4N, L4M, L9S, L0L, L9X)

First Name: ____________________ Last Name: ____________________

Health Card #: ____________________ Version Code: __________

DOB (d/m/y): ____________________

Address: ____

City: ____________________ Province: _ON_

Postal Code: __________

Phone (Main): ____________________ Phone (Other): ____________________

MEDICAL INFORMATION

☐ See attached

Height: ________ ☐m ☐ ft Weight: ________ ☐ lbs ☐ kg BMI: ________

REFERRING CLINICIAN

☑ Please see my patient regarding weight management

Referring Clinician: ________________________________ ☐MD ☐NP

Billing Number: ______________

Address: ____

Phone: ____________________ Fax: ____________________

Clinician Signature: ____________________ Date: ____________________

Our office will contact your client with an appointment time and date.
Please note, information about our program, referral form and Client History Questionnaire can be accessed on our website at www.connectbchc.ca

Client Name: ___________________________

DOB: ___________________________

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CLIENT HISTORY QUESTIONNAIRE

Phone: 705-734-9690 ext. 283
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Please note, this form ***must*** *be sent with referral form.*
This form will take approximately 10 minutes to fill.
Please find more information about the program at www.connectbchc.ca

Section I: Readiness

1. On a scale of 1-10, how important is it to you to lose weight? ____________
2. On a scale of 1-10, how ready do you feel you are to make behaviour changes to support weight loss? ____________
3. If you lost 5-10% of your weight, would you consider that a success? □ Yes □ No
4. To successfully participate in this program, we must be able to arrange an appointment at least once every 2-4 weeks; is this a commitment you are able to make at this time? □ Yes □ No
5. Is there anything you feel your weight is preventing you from being able to do?

   ____

   ____

Section II: Weight History

1. Weight history:
   Current weight? ____________ lbs
   Highest adult weight? ____________ lbs What age? ____________
   Lowest adult weight? ____________ lbs What age? ____________
2. At what age did weight become a concern for you?
   _______________ years old
3. Do you connect your weight change to a specific life event? □ Yes □ No
   If yes, what was it? ____
4. Do you have a desired weight? □ Yes □ No
   If yes, what weight would you like to reach? _______________ lbs

Client Name: ____________________________

DOB: ____________________________

Section III: Lifestyle

1. What best describes your smoking history?
   - □ I have never been a smoker
   - □ I currently smoke (if so, how many cigarettes per day?) ____________
   - □ I quit smoking (if so, how long ago?) ____________

2. Have you ever had a problem with alcohol or drug use? □ Yes □ No

3. Over the past 6 months, has your health prevented you from exercising?
   □ No □ Yes (if yes, please check factors preventing you from exercising)

   □ Overweight □ Arthritis/Joint pain □ Fracture/Sprain
   □ Lack of interest □ Heart problems □ Asthma
   □ Other ____

4. Do you do any planned physical activity? □ Yes □ No
   If yes, what type of activity and how many times per week?
   ____
   ____

5. Are you physically active at work? □ Yes □ No

6. Is there a particular time of day that you find that you are more vulnerable to overeating?
   □ No □ Yes If yes, when? ____

7. Do you consider yourself to be an emotional eater? □ Yes □ No

8. Do you get food cravings that are hard to ignore? □ Yes □ No
   If yes, how strong are they? (1 – very weak, 10 – overwhelming) ___________

9. How often do you skip meals? Any particular meal? __________________________________

10. How often do you eat out or order in a meal? __________________________________

11. Have you ever had an eating disorder? □ Yes □ No

12. Do you have times when you binge (eat a large amount of food in a short amount of time)?
    □ Yes □ No

Client Name: ___________________________

DOB: ___________________________

Section IV: Prior Weight Management Strategies

1. Have you ever taken medications for weight loss?
   - ◻ No
   - ◻ Yes (please check all medications that apply)
     - ◻ Xenical/Orlistat ◻ Contrave ◻ Victoza
     - ◻ Saxenda ◻ Other: ____

2. Have you ever had surgery for weight loss?
   - ◻ No ◻ Yes

   If yes, when? ________________

   - ◻ Lap-band ◻ Roux-en-Y Gastric Bypass
   - ◻ Gastric Sleeve ◻ Vertical Banded Gastroplasty (stomach stapling)
   - ◻ Duodenal Switch ◻ Biliopancreatic Diversion

Section V: Medical Conditions

1. Have you ever been told about any of the following conditions:

Condition			If yes, please specify/record medications and doses:
High blood pressure	◻ Yes	◻ No	___________________
High cholesterol	◻ Yes	◻ No	___________________
Diabetes	◻ Yes	◻ No	___________________
Fatty liver	◻ Yes	◻ No	___________________
Thyroid issues	◻ Yes	◻ No	___________________
Heart issues	◻ Yes	◻ No	___________________
Digestive issues	◻ Yes	◻ No	___________________
Sleep apnea	◻ Yes	◻ No	___________________
Cancer	◻ Yes	◻ No	___________________
Depression	◻ Yes	◻ No	___________________
Post traumatic stress disorder	◻ Yes	◻ No	___________________
Polycystic ovarian syndrome	◻ Yes	◻ No	___________________

2. Please list any other medications, supplements or herbal preparations you take:

   ____

   ____

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My Best Weight Program FAQ

Welcome! The My Best Weight program is offered by Registered Dietitians and Registered Nurses and is medically managed by Dr. Diane Zatelny, MD FCRP (C) at the Barrie Community Health Centre.

What does Best Weight mean?

We throw out concepts like target weight, ideal weight and goal weight in favour of a Best Weight.
Your Best Weight is the weight that you can achieve while living the healthiest lifestyle you can enjoy while maintaining a loyalty to the value of food and drinks, friends and family, celebration and socialization.

What does the program involve?

Losing weight and keeping it off is not as simple as 'eat less and move more.' We now know that obesity is a brain-based chronic disease, just like diabetes or asthma and should be treated as such.
Your Nurse or Dietitian will talk about food choices and exercise but will also focus on the thoughts and emotions that affect your decisions about what you eat. We will discuss the option of using medications to help treat obesity as a chronic disease, but use of medications is NOT mandatory to be a part of this program.

We will provide nutritional information, education and guidance, however our focus is not on providing meal plans.

How much does it cost?

There is no cost to participate.

How much weight can I expect to lose?

In this program, we will provide you with realistic options, based on sound evidence and clinical expertise, that may help you lose 5 – 10% of your starting weight. Studies show that a weight loss of 5% can significantly improve your health.

Here is what to expect:

1. Your first appointment will be with a Nurse or Dietitian for approximately 60 minutes
2. The next appointment will be 15 minutes with a Nurse or Dietitian followed by a 20-minute appointment with Dr. Zatelny for assessment
3. Regular follow ups (every 2 – 4 weeks) will be booked with your Nurse or Dietitian – these can be in-person, over the phone, via email or using video-conferencing and are usually 30-45 minutes long
4. You will see Dr. Zatelny as needed based on your treatment plan

* All appointments are one-on-one with your health care practitioner *

Please visit our website at www.connectbchc.ca for additional information