



PLEASE FAX REFERRALS TO
519-371-9304

GREGORY BECKS MD FRCPC & Associates
Lifestyle Medicine & Specialist Network

“Management of chronic disease through intensive lifestyle modification.”

AROGA LIFESTYLE MEDICINE (COMMON ELIGIBLE CONDITIONS):

- | | | |
|---|---|--|
| <input type="checkbox"/> Obesity and Obesity Related Disease | <input type="checkbox"/> Diabetes Type 2 | <input type="checkbox"/> Dyslipidemia |
| <input type="checkbox"/> Non-Alcoholic Fatty Liver Disease and NASH | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Coronary Artery Disease |
| <input type="checkbox"/> Polycystic Ovarian Syndrome | <input type="checkbox"/> Osteoporosis and Bone Health | <input type="checkbox"/> Cerebrovascular Disease |
| <input type="checkbox"/> Erectile Dysfunction & Hypogonadism | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Other _____ |

The Aroga Lifestyle Medicine specialist consult treats chronic disease with evidence-based & guideline-based intensive-yet-sustainable lifestyle change interventions as primary treatment and when necessary provides pharmacological treatment. Consults and follow ups combine our medical specialist expertise with in-house allied health professionals to optimize outcomes and provide patients with the tools necessary to take control of their own bodies. This specialist consult is fully covered by OHIP in Ontario.

GENERAL INTERNAL MEDICINE and PERIOPERATIVE MEDICINE

Reason for referral (please append a referral letter with details): _____

If Pre-op, what is the proposed OR date: _____

Circle one:

VERY URGENT (within days)

URGENT (within 3 weeks)

NONURGENT (>3 weeks)

Anemia / Hematological Disorders

- | | | |
|--|--|---|
| <input type="checkbox"/> Anemia Consultation | <input type="checkbox"/> General Hematological Disorders | <input type="checkbox"/> Iron Infusion Alone
<i>(ensure you have provided a prescription for Iron Sucrose or Isomaltoside with infusion instructions)</i>
**A \$120 infusion centre charge is applicable. |
|--|--|---|

For all Consultations, we will provide you with a complete internal medicine consultation addressing the reason for referral and ancillary issues, including an investigation and management plan. Please append or copy us the following labs: CBC-d, ferritin, total iron binding capacity, iron saturation index, reticulocyte count

Reason for Referral: _____

PATIENT REFERRAL

NAME		<input type="checkbox"/> M <input type="checkbox"/> F
PHN	DATE OF BIRTH	
TELEPHONE	CELL PHONE	
ADDRESS	EMAIL	
OHIP#	COPIES TO	
REFERRING		

Referring Physician: _____ Billing # _____ MD Signature _____

Please provide and append as much pertinent data as possible. Eg: Lab Reports, Consultant Reports, Imaging Reports, etc. You will get notified about your patient's booked appointment time and date. All consult notes will be sent to your office via fax.

PLEASE SEND ALL REFERRALS TO THE LOCAL FAX LINE: 519-371-9304