

AMARDEEP S. MANGAT MD FRCPC * NAZIA HOSSAIN MD FRCPC & ASSOCIATES

AROGA LIFESTYLE MEDICINE CONSULTS (Common Eligible Conditions)

- | | | |
|--|---|--|
| <input type="checkbox"/> Obesity and Obesity Related Disease | <input type="checkbox"/> Diabetes Type 2 | <input type="checkbox"/> Dyslipidemia |
| <input type="checkbox"/> Metabolic dysfunction-associated steatotic liver disease & MASH | <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"/> Anemia/Iron Deficiency |
| | | <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 may 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.

Please provide any additional information and attach relevant reports (labs, consultant notes, imaging)

Additional Private Pay Services Available for Patients

- | | |
|---|--|
| <input type="checkbox"/> Anemia/Iron Deficiency Consult and Infusion (infusion fee will apply) | <input type="checkbox"/> Registered Dietitian Services |
| <input type="checkbox"/> Iron infusion (infusion fee will apply) | <input type="checkbox"/> Clinical Counseling |
| ** Please fax a copy of the patient's prescription along with this referral form. The medication must be delivered to Aroga directly from the pharmacy to ensure medication safety. | <input type="checkbox"/> Sleep Supports |

Indicate Urgency: VERY URGENT (within days) URGENT (within 3 weeks) NONURGENT (>3 weeks)

MD SIGNATURE

PATIENT INFORMATION: Please complete all fields

NAME	
PHN	DATE OF BIRTH <input type="checkbox"/> M <input type="checkbox"/> F
TELEPHONE	CELL PHONE
ADDRESS	EMAIL
CLINICAL INFORMATION: Please complete all fields	
CLINIC ADDRESS	CLINIC FAX
PRIMARY CARE PRACTITIONER:	OHIP #
COPIES TO	

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: 289-726-2032