

EDEN ENGLISH MD FRCPC * RILEY HICKS MD FRCPC * JASDEEP SALUJA MD FRCPC & ASSOCIATES
MULTISPECIALTY MEDICAL CLINIC ~ IN-PERSON AND TELEMEDICINE CONSULTATIONS AVAILABLE

AROGA LIFESTYLE MEDICINE CONSULTS

Select the primary condition(s) you are requesting a consultation for:

- | | | |
|--|---|--|
| ☐ Obesity and Obesity Related Disease | ☐ Diabetes Type 2 | ☐ Dyslipidemia |
| ☐ Metabolic dysfunction-associated steatotic liver disease & MASH | ☐ Hypertension | ☐ Coronary Artery Disease |
| ☐ Polycystic Ovarian Syndrome | ☐ Osteoporosis and Bone Health | ☐ Cerebrovascular Disease |
| ☐ Erectile Dysfunction & Hypogonadism | ☐ Atrial Fibrillation | ☐ Anemia/Iron Deficiency |
| | | ☐ 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 MSP in BC.

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: _____

Additional Private Pay Services Available for Patients

- | | |
|--|--|
| ☐ Anemia/Iron Deficiency Consult and Infusion (infusion fee will apply) | ☐ Registered Dietitian Services |
| ☐ Iron infusion (infusion fee will apply) | ☐ Clinical Counseling |
| ☐ Sleep Supports | |
- ** 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.

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

Indicate Urgency:

☐ VERY URGENT (within 1 week)

☐ NONURGENT (>3 weeks)

MD SIGNATURE

MSP ID#

PATIENT INFORMATION: Please complete all fields

NAME ☐ M ☐ F

PHN

DATE OF BIRTH

TELEPHONE

CELL PHONE

ADDRESS

EMAIL

CLINICAL INFORMATION: Please complete all fields

CLINIC ADDRESS

CLINIC FAX

PRIMARY CARE PRACTITIONER:

MSP ID #

COPIES TO

PLEASE SEND ALL REFERRALS TO THE CENTRAL FAX LINE: 604-914-2551

Thank you for including us in your patient's care. Our team will notify your office once triage has been completed.