Referral Form
Peak Metabolic Program

2 Kennedy Rd S, Unit 4 A, Brampton ON L6W 3E1
T 437-925-6530 | F 1-866-544-3710
bepeak@peakhuman.ca | www.peakhuman.ca

PEAK HUMAN LABS

Patient Information

Patient Label (If not available, please fill in the form below)

Patient Name _____ Given Name _____ Surname

Date of Birth _____ Year _____ Month _____ Day _____ Gender

Contact Info (complete 1 or more) _____ Phone _____ Secondary Phone _____ Email

Address _____ Address _____ Unit Number (if applicable)

_____ City _____ Province _____ Postal Code

Reason for Consultation

	☐ T2DM	☐ Obesity: BMI >27
	☐ Hypertension	☐ Hypothyroidism
	☐ Hyperlipidemia	
Current Medications (or attach seperately)		

Referring Health Care Practitioner Information

Doctors Name _____ First Name _____ Last Name

***Billing No.** _____ _____ Address

Signature/Date _____ Signature of Health Care Practitioner _____ Year _____ Month _____ Day

Office Information/Stamp

Please fax referrals to our secure fax line: 1-866-544-3710
Email to metabolicclinic@peakhuman.ca