PHYSICIAN REFERRAL FORM
For children and adolescents with obesity

Please print clearly

DATE______________________

Child's Name: ____ **Male or Female**
(last name) (first name)

Child's Age: ___________ **DOB:** (yyyy/mm/dd): ______________________________________

PHN #: ____________________________________

Parent/Guardian's names: ____
mother (last name) (first name)

____
father (last name) (first name)

____
other (please state relationship)

Address:_________________________________ **Tel: (home)**_______________________

____ **(work/cell):**_______________________

____ **PHN:** ___________________________

Reason for Referral:
____
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____

Current Weight_____________**Current Height**________________**BMI**_________

Current Blood Pressure_____________

1. **Growth History (please attach growth charts if available)**

	Date	**Height (in/cm)**	**Weight (lbs/kgs)**
1.			
2.			
3.			
4.			
5.			
6.			

2. **Medical/Psychiatric History (please attach any relevant bloodwork)**

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3. **Family History**

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4. **Appropriateness for nutrition and lifestyle counselling**

Our dietitian and psychologist work with the family to address the biological, psychological, social, and/or familial factors understood to contribute to childhood obesity.

- Are there issues that might impede this child's ability to benefit from a psycho-educational intervention (e.g., learning/cognitive difficulties, behavioural problems, social-emotional or psychiatric concerns)?

  ❑ No ❑ Yes (Please describe): ____

- Are there any other significant stressors affecting this child/family (e.g., recent family separation, parental psychopathology, severe inter-parental conflict)?

  ❑ No ❑ Yes (Please describe): ____

- Has the family expressed interest in being referred for further assessment and assistance including nutrition and lifestyle counselling?

  ❑ No ❑ Yes (Please explain): ____

6. **Additional Comments** - *We value any further insight you may have into this patient's weight problem.*

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Referring physician: ____
(Name) (Practitioner Number)

____
(Complete Address) (Phone number)

Specialty_______________________________________

Family physician: ____
(Name) (Practitioner Number)

____
(Complete Address) (Phone number)

Please FAX to : (250) 755-7946
Attention: Dr. Glynis Marks, Ph.D., Registered Psychologist

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