



Patient Referral Form

(to be completed by the child's physician)

Thank you for your interest in the **Pediatric Weight Clinic**. Our hope is to help your patient experience long-lasting lifestyle changes.

Please complete all information on the form and fax or mail to our office. Once we receive it we will contact the patient's parents, set up an appointment, and notify you of the outcome when the referral process is complete.

All information submitted is treated with the strictest of confidence.

Patient Information:

Patient Name: _____ M/F _____

Date of birth _____ / _____ / _____ PHN# _____
Day/month/year

Address _____

City _____ Province _____ Postal Code _____

Home phone: _____ Cell or work phone: _____

Parent/Guardian Name: _____

Parent email: _____

Patient Medical Information and medications:

Height: _____ m Weight: _____ kg

BMI _____

Current Medications and supplements:

Additional Medical information: (asthma, ADHD, etc.)



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Past interventions for weight control:

Weight loss programs (please list) _____

Physical activity programs (please list) _____

Requested intervention:

- Psychological Assessment and behaviour modification therapy
- Dietary Assessment and Nutrition intervention
- Fitness Assessment and Physical Activity Intervention
- General Education – nutrition, emotional eating, stress management
- Assessment for the Healthy Weights for Healthy Kids Study
- Medical Assessment only

Referring physician:

Physician name: _____

Physician Phone # office _____ fax _____

Practice ID# _____

Address _____

Signature _____

Family has been informed that a cost may be involved with treatment

Family physician (if different from referring physician)

Name _____

Phone _____