Interior Health

Shapedown BC

Public Health
519 Columbia Street
Kamloops, BC V2C 2T8

Phone: 250-851-7558/Fax: 250-851-7301
www.interiorhealth.ca Search: *"Shapedown"*

Kamloops Healthy Weights for Children: *Shapedown BC*
PHYSICIAN REFERRAL FORM

Date of Referral: _____

Child's Full Name:			**Child's age:**
PHN:	**DOB (yyyy/mm/dd):**	**Male** ☐ **Female** ☐ **Other** ☐	
Parent/Guardian's names:	**Mother:**		
	Father:		
	Other (Please state relationship):		
Address:			
City:	**Postal Code:**		
Telephone (home):	**Telephone (work/cell):**		
email address:			

Current Weight (kg)_____ **Current Height (cm)**_____ **BMI** _____ **Current Blood Pressure** _____

****If six months or more has passed between initial referral and the Intake appointment (Virtual), we may have to send family back for updated anthropometrics. ****

1. **Is family aware of referral and willing to commit to a weekly 10 group intervention? Yes ☐ No ☐**
   Is family willing/able to attend 4 hour intake appointment in person in Kamloops, BC? Yes ☐ No ☐

2. **Has the family expressed interest in assistance with nutrition/lifestyle counselling and available to do so virtually?**
   (Please Explain):

_____

2. **Medical/Psychiatric History/Family History Comments** ***(Please attach any blood work from last 6 months & any growth charts)***

_____

_____

Please check all that apply:

☐ **Acanthosis**	☐ **Anxiety /** ☐ **Depression**	☐ **Metabolic Syndrome**
☐ **Autism Spectrum Disorder**	☐ **Nonalcoholic Fatty Liver Disease**	☐ **Psychiatric Concerns**
☐ **Asthma/Respiratory**	☐ **Dyslipidemia**	☐ **Sleep Disorder**
☐ **Activity Limitation/Physical Impairment** *Circle family member:* **CHILD/PARENT**	☐ **Eating Disorder**	☐ **Other:**

3. **Additional Comments** ***(i.e., significant family stressors, language barrier, insight on patient's weight problem, etc.)***

_____

_____

Referring Physician/ Nurse Practitioner: _____ **Practitioner Number:** _____

Complete Address: _____ *Phone Number:* _____

Family Physician: _____ **Practitioner Number:** _____

Complete Address: _____ *Phone Number:* _____

Please FAX completed referral ATTN SHAPEDOWN to: 250-851-7301