

Generation Health Clinic Referral Form

www.generationhealth.ca/clinic

Date:

CHILD INFORMATION

Name:

Date of Birth (dd-mm-yy):

PHN

Male Female Intersex

FAMILY INFORMATION

Guardianship Status:

Lives with both parents/Married/Common Law
(please fill out contact information for both guardians)

Sole Guardianship
(please fill out contact information for the sole guardian)

Joint Guardianship
(please fill out contact information for both guardians)

Other (please specify): _____

Parent/Guardian 1 Name:

Parent/Guardian 2 Name:

Address:

Address:

Primary Phone: Cell Home

Primary Phone: Cell Home

Alternate Phone:

Alternate Phone:

Email Address:

Email Address:

Family ready or interested in making healthy living changes: Yes No

Parents/Guardians aware of referral and have given consent to be referred and contacted (by phone call, email and/or text)? Yes No

At least one parent/caregiver able to speak, write and understand English in a discussion-based group setting
 Yes No

Family willing/able to attend 4-hour intake appointment in person in Kamloops, BC? Yes No

ANTHROPOMETRICS (please attach all available growth charts & data)

Date of Measurements:

Height (cm):

Weight (kg):

BMI:

Blood Pressure:

**If the family cannot travel to an in-person appointment, we may request the family see the referring physician for updated anthropometrics. **

CLINICAL CONCERNS (Please check all that apply)

Reason for Referral: BMI for age >97th %ile

BMI for age >85th %ile with or at high risk of developing comorbidities (see list below)

Comorbidities:

- Insulin resistance/ Prediabetes/ Diabetes
- Dyslipidemia
- Depression/Anxiety
- Obstructive sleep apnea/sleep disordered breathing
- Metabolic Associated Fatty Liver Disease (formerly NAFLD)
- Musculoskeletal pain
- Prehypertension/Hypertension
- PCOS
- Weight-based bullying

Other concerns:

- Neurodiversity (e.g. ASD, ADHD)
- Socio-emotional concerns
- Behavioural problems
- Psychiatric concerns
- High risk family history
- Other (please describe):

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| EXCLUSION CRITERIA | |
|--|----------------------|
| <p>Children/teens must be able to participate in a group program. The program is not appropriate for those with:</p> <ul style="list-style-type: none"> • an active eating disorder • acute mental health concerns (e.g., active self-harm/suicidal ideation, mental health crisis) • uncontrolled behavioural problems (e.g., aggressive behaviour, flight risk, verbal harassment) | |
| PAST MEDICAL HISTORY | |
| <p>Please attach all available consults, recent bloodwork, imaging, diagnostic results.</p> | |
| FAMILY MEDICAL HISTORY | |
| <hr/> <hr/> <hr/> <hr/> | |
| HOME ENVIRONMENT | |
| <p>Significant stressors affecting this child/family:</p> <p> <input type="radio"/> Mental health/addictions concerns <input type="radio"/> Other (please describe): _____ _____ _____ </p> <p> <input type="radio"/> Family conflict <input type="radio"/> Food insecurity </p> | |
| PHYSICIAN/NURSE PRACTITIONER INFORMATION | |
| Referring Practitioner: | Practitioner Number: |
| Specialty: | |
| Address: | |
| Phone: | Fax: |
| | |
| Primary Care Provider: | Practitioner Number: |
| Address: | |
| Phone: | Fax: |

**Please fax the completed referral form to Kamloops Public Health Unit: 250-314-2316.
For any questions, please call 778-362-6810 ext: 10813.**