



THE KIDFIT HEALTH AND WELLNESS CLINIC
Referral Ages (2- 17 years)

KidFit is a paediatric health and wellness clinic, for children who meet the following criteria:

- **Ages 2 to 17 years** (Due to the length & nature of the program, referrals must be received prior to child's 17th birthday)
- **BMI of greater than, or equal to the 95th percentile** (CDC Growth Chart).
- **BMI of greater than, or equal to the 97th percentile** (WHO Growth Chart of Canada).
- **MUST have a current growth chart**

Please fax completed referral form, all growth charts and any pertinent blood work from the past 12 months to KidFit Clinic at:
Fax: (905) 813- 4128 or call **(905) 813- 4120** with any questions.

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|---|--|-------------------------------------|--|--|---|
| Referrer Information | Name of Referring Source (MD): | | Billing Number: | Office Phone Number: | Office Fax Number: |
| | Name of Family Physician: | | Office Phone Number: | | Office Fax Number: |
| Client Information | Last Name: | | First Name: | | Middle Initial: |
| | <input type="checkbox"/> Female <input type="checkbox"/> Male | Age: | Date of Birth (yyyy- mm- dd): | | Health Card Number/Version Code: |
| | <input type="checkbox"/> Alternative | Grade: | | | |
| | Address: | | City: | | Postal Code: |
| | Parent/ Guardian Name (last, first): | | Relationship to Client: | | Language Spoken: |
| Home Phone Number: | | Alternate Phone/Cell Number: | | Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Anthropometry | Date of Assessment (yyyy- mm- dd): | | Weight: | Height: | BMI for Age Percentile (Ages 2- 17 yrs): |
| | | | kg | cm | _____ |
| All growth charts attached (mandatory): <input type="checkbox"/> | | | <input type="checkbox"/> CDC <input type="checkbox"/> WHO | | |
| Co- Morbidities | (Please check all that apply) | | <input type="checkbox"/> Slipped Capital Femoral Epiphysis (SCFE) <input type="checkbox"/> Obstructive Sleep Apnea <input type="checkbox"/> Gastroesophageal Reflux <input type="checkbox"/> Polycystic Ovary Syndrome <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> ADHD <input type="checkbox"/> Neurodevelopmental Disorders | | <input type="checkbox"/> Other (i.e other co- morbidities or underlying medical conditions) Please Specify: _____ _____ _____ |
| | <input type="checkbox"/> Hypertension <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Pre- diabetes <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Disordered Eating <input type="checkbox"/> Non- alcoholic Fatty Liver Disease <input type="checkbox"/> Gallbladder Disease <input type="checkbox"/> Blount's Disease | | | | |
| Signature | Please include all labs, imaging, growth charts etc. Appointments will not be booked until all required information has been provided. Please note, while patients are awaiting elective consultation, KidFit cannot accept responsibility for their health care until the patient has been seen. As their referring professional, you remain responsible for all their medical related care. | | | | |
| | Signature of Referring MD: _____ Date: _____ | | | | |

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