PHYSICIAN REFERRAL FORM – "FOR HEALTH" STUDY

FOR HEALTH: A Family-ORiented Healthy Eating, Activity and Lifestyle Training with Hands-on experience. A new, community-based Obesity Intervention Study for preschool children & their families.

Inclusion criteria: 1.) Children aged 2 years 9 month - 6 (on study entry) with primary overweight or obesity (BMI ≥ 85th percentile for age & sex on WHO Growth Charts for Canada, 2010); 2.) Family meets "Confidence to implement changes" requirement (minimum score 12, max. 1 item with a score of 1 ("not confident"); 3.) At least one caregiver committed to attend all the program sessions with the child; 4.) Caregiver is agreeing to complete the study questionnaires (3-day food record, physical activity, & quality of life questionnaire) at the required time points; 5.) Caregivers agree to provide a deposit of $50.00.
Exclusion criteria: 1.) Chronic medical conditions (e.g. type 1 diabetes mellitus, heart-, gastrointestinal-, or kidney diseases, uncontrolled asthma, other physical, developmental or psychological disabilities that could limit extent of study participation incl. ADHD); 2.) Regular use of medications that could limit extent of study participation; 3.) Other concurrent or recently (last 12 months) received structured obesity treatment program; 4.) Inability to read, speak, and/or understand English.

Referring Physician

Name (print): ______________ Phone number: _____________ Referral date/time: ________________________

Office location: _______________ Dietitian involved (name/phone)? _____________________________________

Patient demographic and social information

Name: _________________________________ Date of Birth: _____________________________

Age (years): _______ Gender: ☐ Male ☐ Female Phone number: ______________________________

Street Address: ___________________________ Postal code: ________________ City: _____________________

Name mother: _________________________ Name father: __________________________

Primary caregiver / custody: ☐ Both parents (joint) ☐ Mother ☐ Father
Financial Concerns: ☐ Yes ☐ No

Primary referral diagnosis: Primary overweight or obesity (BMI ≥ 85th percentile) ☐ Yes ☐ No

Please list any other diagnoses (e.g. ADHD) or obesity-related comorbidities:

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Current height (cm): _______, weight (kg): _______, BMI (kg/m^2): _________ Date: ________________________

Last 2 blood pressures: ___ /___, Date: __________; ___ /___, Date: ___________ Acanthosis? ☐ Yes ☐ No

Please list any current or recent (last 6 months) medications: ____

Food or Drug allergies: ☐ No ☐ Yes (specify): ____

Vaccinated as per schedule? ☐ Yes ☐ No (specify what's missing): ___________________________

Any previous obesity treatment / intervention: ☐ No ☐ Yes (date & details):

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Relevant recent physical exam findings? ☐ No ☐ Yes (date & details): _________________________________

Parental confidence "Confidence to implement changes" score: __________ (Please fax with referral form)

Other requests / comments of referring physician ____

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Referring Physician Signature ____
Supporting documents: ☐ Growth Chart ☐ Confidence Assessment Fax to: (519) 685-8499