BRITISH COLUMBIA | HealthLinkBC

Eating and Activity Program for Kids Referral

Fax completed referral to: 250-953-0493

Referring Practitioner: _____
Office Address: _____
_____
Office Phone: _____
Office Fax: _____

Client Name: _____
Gender: _____
PHN: _____
DOB: _____
Date of Referral: _____

Parent/Guardian Name: _____
Relationship to Client: _____
Address: _____
_____
Home Phone: _____
Alternate Phone: _____

☐ **I confirm that the parent/guardian has authorized this referral.**

☐ **I confirm that the child (who has decision-making capacity) has authorized this referral.**

☐ **Growth Charts (Please attach with referral)**

Weight: _____ ☐ kg ☐ lbs.	Height: _____ ☐ cm ☐ inches	BMI: _____ (kg/m^2)	BMI: _____ percentile	BP: _____ mmHg	Waist Circumference: _____ ☐ cm ☐ inches

Medical History:

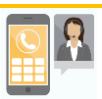
☐ Dyslipidemia
☐ Hypertension
☐ Metabolic Syndrome
☐ Type 2 Diabetes
☐ Gastrointestinal _____
☐ Sleep Disorder _____
☐ Eating Disorder
☐ Depression
☐ Anxiety
☐ Psychiatric Concerns
☐ ASD
☐ ADHD
☐ Cognitive _____
☐ Asthma/Respiratory
☐ Neurodevelopment
☐ Activity Limitation/Physical Impairment
☐ Hearing or Visual Impairment
☐ Other _____

Bloodwork: *Bloodwork is recommended. Please include the following tests plus other relevant results that have been completed within the past 6 months*

☐ Hematology Profile
☐ TSH
☐ AST
☐ Lipid Profile
☐ Albumin
☐ ALT
☐ Basic Metabolic Profile
☐ Alk Phos
☐ Other: _____

Additional Information: *Does the family have any of the following issues/barriers that could inhibit weight management?*

☐ Financial Issues
☐ Family/Social Functioning
☐ Literacy Barriers
☐ Translation services are available. Please specify language:_____
☐ Other _____



To contact us:
Dial *8-1-1*, ask for the *Eating and Activity Program for Kids*