fraserhealth

generationhealth | Clinic
Healthy Living Programs for Families

Generation Health Clinic Referral Form

www.generationhealth.ca

Date:

REFERRAL TO *(please check one)*	
○ Program in **English** (Tel: 604-365-1697) At least one parent/caregiver able to speak, write and understand English in a discussion-based group setting	○ **South Asian** Program (Tel: 236-332-3786) Culturally adapted program for families of South Asian background; group program delivered in both English and Punjabi
CHILD INFORMATION	
Name:	Date of Birth (yyyy-mm-dd):
PHN:	Male ○ Female ○ Intersex ○
FAMILY INFORMATION	
Guardianship Status: ○ Lives with both parents/Married/Common Law *(please fill out contact information for both guardians)* ○ Joint Guardianship *(please fill out contact information for both guardians)*	○ Sole Guardianship *(please fill out contact information for the sole guardian)* ○ Other *(please specify)*: ______
Parent/Guardian 1 Name:	Parent/Guardian 2 Name:
Address:	Address:
City: Postal Code:	City: Postal Code:
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	

ANTHROPOMETRICS *(please attach all available growth charts & data)*			
Date of Measurements:			
Height (cm):	Weight (kg):	BMI:	Blood Pressure:

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 complications (see list below)

Complications:
- ○ Insulin resistance/Prediabetes/Diabetes
- ○ Dyslipidemia
- ○ Depression/Anxiety
- ○ Obstructive sleep apnea/sleep disordered breathing
- ○ Metabolic dysfunction-associated steatotic liver disease (MASLD)
- ○ Musculoskeletal pain
- ○ Prehypertension/Hypertension
- ○ PCOS

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

BRITISH COLUMBIA

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EXCLUSION CRITERIA

Children/teens must be able to participate in a group program. The program is **not** appropriate for those with:
- 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

Please attach all available consults, recent bloodwork, imaging, diagnostic results.

FAMILY MEDICAL HISTORY

Please detail: ______________________

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HOME ENVIRONMENT

Significant stressors affecting this child/family:

- ○ Mental health/addictions concerns
- ○ Family conflict
- ○ Food insecurity
- ○ Other (please describe): ______________________

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PHYSICIAN/NURSE PRACTITIONER INFORMATION

Referring Provider:	MSP Number:
Specialty:	
Address:	
Phone:	Fax:
Primary Care Provider:	MSP Number:
Address:	
Phone:	Fax:

Please fax the completed referral form to Langley Memorial Hospital: 604-534-4088.
For any questions, please refer to the telephone numbers in the "Referral to" section.

BRITISH COLUMBIA