Generation Health Clinic Referral Form

www.generationhealth.ca/clinic

Date:

REFERRAL TO *(please check one)*	
○ **English** Program (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 (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)

○ 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:
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 comorbidities (see list below)

Cormorbidities:
- ○ 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
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

HOME ENVIRONMENT	
Significant stressors affecting this child/family:	
☐ Mental health/addictions concerns	☐ Other (please describe):
☐ Family conflict	
☐ Food insecurity	

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 Langley Memorial Hospital: 604-514-7410.
For any questions, please refer to the telephone numbers in the "Referral to" section.