



Generation Health Clinic Referral Form www.generationhealth.ca/clinic

email and/or text)?	Date:	www.generatio	mreattr.ca/clinic		
Date of Birth (dd-mm-yy): PHN Male Female Intersex	CHILD INFORMATION				
PHN	Name:				
Guardianship Status: O Lives with both parents/Married/Common Law (please fill out contact information for both guardians) O Joint Guardianship (please fill out contact information for both guardians) O Ther (please specify): O Ther (please describe):	Date of Birth (dd-mm-yy):				
Guardianship Status: O Lives with both parents/Married/Common Law (please fill out contact information for both guardians) O Joint Guardianship (please fill out contact information for both guardians) Parent/Guardian 1 Name: Address: Primary Phone: O Cell O Home Primary Phone: O Cell O Home Alternate Phone: Email Address: Family ready or interested in making healthy living changes: O Yes O No Parents/Guardians aware of referral and have given consent to be referred and contacted (by phone call, email and/or text)? O Yes O No Family willing/able to attend 4-hour intake appointment in person in Kamloops, BC? O Yes O No ANTHROPOMETRICS (please attach all available growth charts & data) Date of Measurements: Height (cm): Weight (kg): BMI: Blood Pressure: **If the family cannot travel to an in-person appointment, we may request the family see the referring physician for updated anthropometrics. ** **If the family cannot travel to an in-person appointment, we may request the family see the referring physician for updated anthropometrics. ** **If the family cannot travel to an in-person appointment, we may request the family see the referring physician for updated anthropometrics. ** **If the family cannot travel to an in-person appointment, we may request the family see the referring physician for updated anthropometrics. ** **CLINICAL CONCERNS (Please check all that apply) Reason for Referral: O BMI for age >97th %ile O BMI for age >85th %ile with or at high risk of developing comorbidities (see list below) **Other concerns: O Rehavioural problems O Socio-emotional concerns O Behavioural problems O Hatabolic Associated Fatty Liver Disease (formerly NAFLD) O Other (please describe):	PHN		Male O Female O Inte	rsex O	
Clives with both parents/Married/Common Law (please fill out contact information for both guardians) O Joint Guardianship (please fill out contact information for both guardians) Parent/Guardian 1 Name: Address: Primary Phone: ○ Cell ○ Home Primary Phone: ○ Cell ○ Home Alternate Phone: 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 Family milling/able to attend 4-hour intake appointment in person in Kamloops, BC? ○ Yes ○ No ANTHROPOMETRICS (please attach all available growth charts & data) Date of Measurements: Height (cm): Weight (kg): BMI: Blood Pressure: ***If the family cannot travel to an in-person appointment, we may request the family see the referring physician for updated anthropometrics. *** 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: ○ Neurodiversity (e.g. ASD, ADHD) ○ Socio-emotional concerns ○ Dyslipidemia ○ Depression/Anxiety ○ Ostructive sleep apnea/sleep disordered breathing ○ Metabolic Associated Fatty Liver Disease (formerly NAFLD) ○ High risk family history ○ Other (please describe):					
(please fill out contact information for both guardians) Joint Guardianship (please fill out contact information for both guardians) Parent/Guardian 1 Name: Address: Primary Phone:					
Parent/Guardian 2 Name: Address: Primary Phone:	 Lives with both parents/Married/Common Law (please fill out contact information for <u>both</u> guardians) Joint Guardianship 		(please fill out contact information for the <u>sole</u> guardian)		
Address: Primary Phone:			Parent/Guardian 2 Name		
Alternate Phone: Email Address: Email Address: 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 Family willing/able to attend 4-hour intake appointment in person in Kamloops, BC? \(\) Yes \(\) No ANTHROPOMETRICS (please attach all available growth charts & data) Date of Measurements: Height (cm): Weight (kg): BMl: Blood Pressure: **If the family cannot travel to an in-person appointment, we may request the family see the referring physician for updated anthropometrics. *** 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: \(\) Neurodiversity (e.g. ASD, ADHD) \(\) Socio-emotional concerns \(\) Behavioural problems \(\) Psychiatric concerns \(\) Behavioural problems \(\) Psychiatric concerns \(\) High risk family history \(\) Other (please describe):					
Email Address: Family ready or interested in making healthy living changes:	Primary Phone: O Cell O Home		Primary Phone: O Cell O Home		
Family ready or interested in making healthy living changes: Parents/Guardians aware of referral and have given consent to be referred and contacted (by phone call, email and/or text)? Yes	Alternate Phone:		Alternate Phone:		
Parents/Guardians aware of referral and have given consent to be referred and contacted (by phone call, email and/or text)?	Email Address:		Email Address:		
consent to be referred and contacted (by phone call, email and/or text)?	Family ready or interested in making healthy living changes: O Yes O No				
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Reason for Referral: OBMI for age >97th %ile OBMI for age >85th %ile with or at high risk of developing comorbidities (see list below) Cormorbidities: Other concerns: Outer concerns:					
Obstructive sleep apnea/sleep disordered breathing ○ Metabolic Associated Fatty Liver Disease (formerly NAFLD) ○ BMI for age >85th %ile with or at high risk of developing comorbidities (see list below) Other concerns: ○ Neurodiversity (e.g. ASD, ADHD) ○ Socio-emotional concerns ○ Behavioural problems ○ Psychiatric concerns ○ High risk family history ○ Other (please describe):	CLINICAL CONCERNS (Please check all that apply)				
 ○ Insulin resistance/ Prediabetes/ Diabetes ○ Dyslipidemia ○ Depression/Anxiety ○ Obstructive sleep apnea/sleep disordered breathing ○ Metabolic Associated Fatty Liver Disease (formerly NAFLD) ○ Musculoskeletal pain ○ Neurodiversity (e.g. ASD, ADHD) ○ Behavioural problems ○ Psychiatric concerns ○ High risk family history ○ Other (please describe): 					
 ○ Prehypertension/Hypertension ○ PCOS ○ Weight based bullving 	 Insulin resistance/ Prediabetes/ Diabetes Dyslipidemia Depression/Anxiety Obstructive sleep apnea/sleep disordered breathing Metabolic Associated Fatty Liver Disease (formerly NAFL Musculoskeletal pain Prehypertension/Hypertension 		 Neurodiversity (e.g. ASD, ADHD) Socio-emotional concerns Behavioural problems Psychiatric concerns High risk family history 		







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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, im	naging, diagnostic results.				
FAMILY MEDICAL HISTORY					
HOME F	NVIRONMENT				
Significant stressors affecting this child/family:	NVIIXONIBILITI				
Mental health/addictions concerns	Other (please describe):				
○ Family conflict					
○ Food insecurity					
PHYSICIAN/NURSE PRACTITIONER INFORMATION					
Referring Practitioner:	Practitioner Number:				
Specialty:					
Address:					
Phone:	Fax:				
Thome.	1 44.				
Primary Care Provider:	Practitioner Number:				
Address:					
Phone:	Fax:				

Please fax the completed referral form to Kamloops Public Health Unit: 250-314-2316. For any questions, please call 778-362-6810 ext: 10813.

