Interior Health

generationhealth Healthy Living Programs for Families | Clinic

Generation Health Clinic Referral Form

www.generationhealth.ca/clinic

Date:

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	**At least one parent/caregiver able to speak, write and understand English in a discussion-based group setting** ☐ 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):	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:	**Other concerns:**
☐ Insulin resistance/ Prediabetes/ Diabetes	☐ Neurodiversity (e.g. ASD, ADHD)
☐ Dyslipidemia	☐ Socio-emotional concerns
☐ Depression/Anxiety	☐ Behavioural problems
☐ Obstructive sleep apnea/sleep disordered breathing	☐ Psychiatric concerns
☐ Metabolic Associated Fatty Liver Disease (formerly NAFLD)	☐ High risk family history
☐ Musculoskeletal pain	☐ Other (please describe):
☐ Prehypertension/Hypertension	_____
☐ PCOS	_____
☐ Weight-based bullying	_____

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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
- ❍ Family conflict
- ❍ Food insecurity
- ❍ Other (please describe):

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 Kamloops Public Health Unit: 250-314-2316.
For any questions, please call 778-362-6810 ext: 10813.

BRITISH COLUMBIA