Vancouver CoastalHealth

generationhealth Healthy Living Programs for Families | Clinic

# Generation Health Clinic - Program in Chinese Referral Form

www.generationhealth.ca

Date:

| 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 | **At least one parent/caregiver able to speak, write and understand English in a discussion-based group setting** ❍ 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):

_____

_____

**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)

# Generation Health Clinic - Program in Chinese Referral Form

www.generationhealth.ca

| PAST MEDICAL HISTORY |
|---|
| *Please attach all available consults, recent bloodwork, imaging, diagnostic results.* |

| FAMILY MEDICAL HISTORY |
|---|
| Please detail: |

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

| 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 Richmond Place: 236-429-3690.**
**For any questions, please call 604-233-3129.**