

## Generation Health Clinic- Program in Chinese Referral Form

[www.generationhealth.ca/clinic](http://www.generationhealth.ca/clinic)

Date:

### CHILD INFORMATION

Name:

Date of Birth (dd-mm-yy):

PHN: <input style="width: 90%;" type="text"/>	Male <input type="radio"/> Female <input type="radio"/> Intersex <input type="radio"/>
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### FAMILY INFORMATION

Guardianship Status:

<input type="radio"/> Lives with both parents/Married/Common Law <i>(please fill out contact information for <u>both</u> guardians)</i>	<input type="radio"/> Sole Guardianship <i>(please fill out contact information for the <u>sole</u> guardian)</i>
<input type="radio"/> Joint Guardianship <i>(please fill out contact information for <u>both</u> guardians)</i>	<input type="radio"/> Other <i>(please specify):</i> _____

Parent/Guardian 1 Name: <input style="width: 90%;" type="text"/>	Parent/Guardian 2 Name: <input style="width: 90%;" type="text"/>
Address: <input style="width: 90%;" type="text"/>	Address: <input style="width: 90%;" type="text"/>
Primary Phone: <input type="radio"/> Cell <input type="radio"/> Home	Primary Phone: <input type="radio"/> Cell <input type="radio"/> Home
Alternate Phone: <input style="width: 90%;" type="text"/>	Alternate Phone: <input style="width: 90%;" type="text"/>
Email Address: <input style="width: 90%;" type="text"/>	Email Address: <input style="width: 90%;" type="text"/>

Family ready or interested in making healthy living changes:  Yes  No

<b>Parents/Guardians aware of referral and have given consent to be referred and contacted (by phone call, email and/or text)?</b> <input type="radio"/> Yes <input type="radio"/> No	<b>At least one parent/caregiver able to speak, write and understand English in a discussion-based group setting</b> <input type="radio"/> Yes <input type="radio"/> No
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### ANTHROPOMETRICS *(please attach all available growth charts & data)*

Date of Measurements:

Height (cm): <input style="width: 90%;" type="text"/>	Weight (kg): <input style="width: 90%;" type="text"/>	BMI: <input style="width: 90%;" type="text"/>	Blood Pressure: <input style="width: 90%;" type="text"/>
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### 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)

<b>Cormorbidities:</b> <input type="radio"/> Insulin resistance/ Prediabetes/ Diabetes <input type="radio"/> Dyslipidemia <input type="radio"/> Depression/Anxiety <input type="radio"/> Obstructive sleep apnea/sleep disordered breathing <input type="radio"/> Metabolic Associated Fatty Liver Disease (formerly NAFLD) <input type="radio"/> Musculoskeletal pain <input type="radio"/> Prehypertension/Hypertension <input type="radio"/> PCOS <input type="radio"/> Weight-based bullying	<b>Other concerns:</b> <input type="radio"/> Neurodiversity (e.g. ASD, ADHD) <input type="radio"/> Socio-emotional concerns <input type="radio"/> Behavioural problems <input type="radio"/> Psychiatric concerns <input type="radio"/> High risk family history <input type="radio"/> 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)

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PAST MEDICAL HISTORY	
<p><i>Please attach all available consults, recent bloodwork, imaging, diagnostic results.</i></p>	
FAMILY MEDICAL HISTORY	
<hr/> <hr/> <hr/> <hr/>	
HOME ENVIRONMENT	
<p>Significant stressors affecting this child/family:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><input type="radio"/> Mental health/addictions concerns</p> <p><input type="radio"/> Family conflict</p> <p><input type="radio"/> Food insecurity</p> </div> <div style="width: 45%;"> <p><input type="radio"/> Other (please describe):</p> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <hr style="border: 0; border-top: 1px solid black;"/> </div> </div>	
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 Richmond Place: 604-233-3198.  
For any questions, please call 604-233-3129.**