



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

email and/or text)?	Date:	www.generatio	meaith.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 ○ Female ○ Intersex ○		
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  Alternate Phone:  Email Address:  Parents/Guardians aware of referral and have given consent to be referred and contacted (by phone call, email and/or text)? ○ 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:  **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):		FAMILY INF	ORMATION		
(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:	Guardianship Status:				
Parent/Guardian 2 Name:  Address:  Primary Phone:	<ul> <li>(please fill out contact information for <u>both</u> guardians)</li> <li>○ Joint Guardianship</li> </ul>		(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 i	n making healthy living changes:	○ 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	consent to be referred and contacted (by phone call,		understand English in a discussion-based group setting		
Date of Measurements:  Height (cm):  **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:	Family willing/able to attend 4-hour intake appointment in person in Kamloops, BC? O Yes O No				
Height (cm):  **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:	ANTHROPOMETRICS (please attach all available growth charts & data)				
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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)				
<ul> <li>○ Insulin resistance/ Prediabetes/ Diabetes</li> <li>○ Dyslipidemia</li> <li>○ Depression/Anxiety</li> <li>○ Obstructive sleep apnea/sleep disordered breathing</li> <li>○ Metabolic Associated Fatty Liver Disease (formerly NAFLD)</li> <li>○ Musculoskeletal pain</li> <li>○ Neurodiversity (e.g. ASD, ADHD)</li> <li>○ Behavioural problems</li> <li>○ Psychiatric concerns</li> <li>○ High risk family history</li> <li>○ Other (please describe):</li> </ul>					
O PCOS	<ul> <li>Insulin resistance/ Prediabetes/ Diabetes</li> <li>Dyslipidemia</li> <li>Depression/Anxiety</li> <li>Obstructive sleep apnea/sleep disordered breathing</li> <li>Metabolic Associated Fatty Liver Disease (formerly NAFL</li> <li>Musculoskeletal pain</li> <li>Prehypertension/Hypertension</li> </ul>		<ul> <li>Neurodiversity (e.g. ASD, ADHD)</li> <li>Socio-emotional concerns</li> <li>Behavioural problems</li> <li>Psychiatric concerns</li> <li>High risk family history</li> </ul>		







## **Generation Health Clinic Referral Form**

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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 N	MEDICAL HISTORY			
Please attach all available consults, recent bloodwork	, imaging, diagnostic results.			
FAMILY MEDICAL HISTORY				
HOME	E ENVIRONMENT			
Significant stressors affecting this child/family:	- LIVERCOMMENT			
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 Kamloops Public Health Unit: 250-314-2316. For any questions, please call 778-362-6810 ext: 10813.

