Provincial Health Services Authority

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

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 comorbidities (see list below)

Cormorbidities:
- ○ Insulin resistance/ Prediabetes/ Diabetes
- ○ Dyslipidemia
- ○ Depression/Anxiety
- ○ Obstructive sleep apnea/sleep disordered breathing
- ○ Metabolic Associated Fatty Liver Disease (formerly NAFLD)
- ○ Musculoskeletal pain
- ○ Prehypertension/Hypertension
- ○ PCOS
- ○ Weight-based bullying

Other concerns:
- ○ Neurodiversity (e.g. ASD, ADHD)
- ○ Socio-emotional concerns
- ○ Behavioural problems
- ○ Psychiatric concerns
- ○ High risk family history
- ○ 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)

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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 BC Children's Hospital: 604-875-2388
For any questions, please call 604-875-2345 ext 5984.

BRITISH COLUMBIA