Healthy Eating and Activity Program

PIN Card Impression Area

Referral Form

Date of referral: ____________________ Health Card or PIN: _________________________

Patient Name: ____

DOB: __________ Height: __________ Weight: ___________ BMI: ____________

Parent/Guardian Name: ____

Parent/Guardian Phone: _______________________ E-mail:___________________________

Program Interest: ____ Hip Kids ____ REACH

Referring Physician: ____

Referring Physician Phone: ____________________ Fax: ____________________________

Fax referral to: 519-685-8130

Coordinator: 519-685-8100
Children's Hospital, London Health Sciences Centre,
800 Commissioners Rd, E. London ON N6A 5W9