# PHYSICIAN REFERRAL FORM – "FOR HEALTH" STUDY

**FOR HEALTH: A Family-ORiented Healthy Eating, Activity and Lifestyle Training with Hands-on experience. A new, community-based Obesity Intervention Study for preschool children & their families.**

**Inclusion criteria:** 1.) Children aged 2 years 9 month - 5 (on study entry) with primary overweight or obesity (BMI $\geq 85^{th}$ percentile for age & sex on WHO Growth Charts for Canada, 2010); 2.) Family meets "Confidence to implement changes" requirement (minimum score 12, max. 1 item with a score of 1 ("not confident"); 3.) At least one caregiver committed to attend all the program sessions with the child; 4.) Caregiver is agreeing to complete the study questionnaires (3-day food record, physical activity, & quality of life questionnaire) at the required time points; 5.) Caregivers agree to provide a deposit of $50.00.
**Exclusion criteria:** 1.) Chronic medical conditions (e.g. type 1 diabetes mellitus, heart-, gastrointestinal-, or kidney diseases, uncontrolled asthma, other physical, developmental or psychological disabilities that could limit extent of study participation incl. ADHD); 2.) Regular use of medications that could limit extent of study participation; 3.) Other concurrent or recently (last 12 months) received structured obesity treatment program; 4.) Inability to read, speak, and/or understand English.

**Referring Physician**

Name (print): _____ Phone number: _____Referral date/time: _____

Office location: _____ Dietitian involved (name/phone)? _____

**Patient demographic and social information**

Name: _____ Date of Birth: _____

Age (years): _____ Gender: ☐ Male ☐ Female Phone number: _____

Street Address: _____ Postal code: _____ City:_____

Name mother: _____ Name father: _____

Primary caregiver / custody: ☐ Both parents (joint) ☐ Mother ☐ Father
Financial Concerns: ☐ Yes ☐ No

**Primary referral diagnosis:** Primary overweight or obesity (BMI $\geq 85^{th}$ percentile) ☐ Yes ☐ No

Please list any other diagnoses (e.g. ADHD) or obesity-related comorbidities:

_____

Current height (cm): _____, weight (kg): _____, BMI (kg/m$^2$): _____ Date: _____

Last 2 blood pressures: ___ /___, Date: _____; ___ /___, Date: _____ Acanthosis? ☐ Yes ☐ No

Please list any current or recent (last 6 months) medications: _____

Food or Drug allergies: ☐ No ☐ Yes (specify): _____

Vaccinated as per schedule? ☐ Yes ☐ No (specify what's missing):_____

Any previous obesity treatment / intervention: ☐ No ☐ Yes (date & details):

_____

Relevant recent physical exam findings? ☐ No ☐ Yes (date & details): _____

Parental confidence "Confidence to implement changes" score: _____ (Please fax with referral form)

Other requests / comments of referring physician _____

_____

Referring Physician Signature _____
Supporting documents: ☐ Growth Chart ☐ Confidence Assessment Fax to: (519) 685-8499