



Healthy Eating and Activity Program Referral Form

PIN Card Impression Area

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