

Generation Health Clinic Virtual English Program Referral Form

Date:

www.generationhealth.ca/clinic

CHILD INFORMATION

Name:

Date of Birth (dd-mm-yy):

PHN

Male Female Intersex

CARE MODEL

Please choose one of the following:

- Family will travel to Nanaimo for medical assessment by Generation Health Clinic physician
- Shared Care Model for medical assessment (comprehensive physical examination to be done by referring physician or nurse practitioner in collaboration with Generation Health Clinic physician)

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):

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EXCLUSION CRITERIA	
<p>Children/teens must be able to participate in a group program. The program is not appropriate for those with:</p> <ul style="list-style-type: none"> • 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 MEDICAL HISTORY	
<p>Please attach all available consults, recent bloodwork, imaging, diagnostic results.</p>	
FAMILY MEDICAL HISTORY	
<hr/> <hr/> <hr/> <hr/>	
HOME ENVIRONMENT	
<p>Significant stressors affecting this child/family:</p> <p> <input type="radio"/> Mental health/addictions concerns <input type="radio"/> Other (please describe): _____ _____ _____ </p> <p> <input type="radio"/> Family conflict <input type="radio"/> Food insecurity </p>	
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: 236-429-3635.
For any questions, please call 236-833-9673.**