BC CHILDREN'S HOSPITAL
An agency of the Provincial Health Services Authority
V2-207 Clinical Support Building
948 West 28th Avenue
Vancouver, BC V5Z 4H4
Phone: 604-875-2345 ext. 5984
Fax: 604-875-2388

Shapedown BC

SHAPEDOWN
BC Physician Referral Form

Date: _____ *Please print clearly or fill in electronically*

Child's Full Name: _____ **Male** ☐ **or** **Female** ☐

Child's Age: _____ **DOB (dd-mmm-yyyy):** _____ **PHN #:** _____

Parent/Guardian's names: Mother: _____
Father: _____
Other (please state relationship): _____

Address: _____

Tel: (home) _____ **Tel: (work)** _____ **Tel: (cell)** _____

Reason for Referral:

Current Weight _____ **Current Height** _____ **BMI** _____ **Current Blood Pressure** _____

1. Growth History (please attach growth charts if available)

	Date	Height (in/cm)	Weight (lbs/kgs)
1.			
2.			
3.			
4.			
5.			
6.			

2. Medical/Psychiatric History (please attach any relevant blood work)

BRITISH COLUMBIA | HealthyFamiliesBC

3. Family History

4. Appropriateness for the Shapedown BC Program

Entry into the program is considered not only along medical parameters, but the following must also be met:

Participation requires that the patient and parents attend and be:

1. motivated and ready to make change
2. prepared to attend ongoing sessions
3. willing and able to complete homework assignments regularly

5. Please help us to assess whether this patient and their family are suitable for the Shapedown BC program by completing the following questions:

- Are there issues that might impede this child's ability to benefit from a psycho-educational ***group*** intervention (e.g., learning/cognitive difficulties, behavioural problems, social-emotional or psychiatric concerns)?

  ☐ No ☐ Yes (Please describe): _____

- Are there any other significant stressors affecting this child/family (e.g., recent family separation, parental psychopathology, severe inter-parental conflict)?

  ☐ No ☐ Yes (Please describe): _____

- Has the family expressed interest in being referred for further assessment and assistance including nutrition and lifestyle counseling?

  ☐ No ☐ Yes (Please explain): _____

- The program is currently available in <u>English only</u>. Is at least one parent/caregiver able to:

  Speak and understand English in a discussion-based group setting? ☐ No ☐ Yes

  Complete written activities in a workbook ☐ No ☐ Yes

6. Additional Comments - *We value any further insight you may have into this patient's weight problem.*

Referring Physician: _____ Practitioner Number: _____

Specialty: _____

Complete Address: _____ Phone Number: _____

Family Physician: _____ Practitioner Number: _____

Complete Address: _____ Phone Number: _____

Please FAX to: 604 875-2388

Attention: Hardip Panglee Mangat