Provincial Health Services Authority

generationhealth Healthy Living Programs for Families | Clinic

Generation Health Clinic Virtual English Program Referral Form

www.generationhealth.ca/clinic

Date:

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):

_____

_____

BRITISH COLUMBIA

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EXCLUSION CRITERIA

Children/teens must be able to participate in a group program. The program is **not** appropriate for those with:
- 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

Please attach all available consults, recent bloodwork, imaging, diagnostic results.

FAMILY MEDICAL HISTORY

HOME ENVIRONMENT

Significant stressors affecting this child/family:

❍ Mental health/addictions concerns
❍ Family conflict
❍ Food insecurity
❍ Other (please describe): _____

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.

BRITISH COLUMBIA