

Richmond Public Health
8100 Granville Ave.
Richmond, BC V6Y3T6
Tel: 604-233-3150 Ext. 5584
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Shapedown BC Program in Chinese

A Partnership between the Centre for Healthy Weights: Shapedown BC and Vancouver Coastal Health

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)

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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 family speaks which of the following languages (check all applicable):
☐ English ☐ Cantonese ☐ Mandarin (Others): _____

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: 604-233-3198

Attention: Amy Chow, R.D./Program Coordinator

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