BC Children's Hospital Shapedown BC Virtual Program
Referral Form
(please fill in electronically and indicate which care model you are requesting)

DATE: _____

CHILD INFORMATION	
Name:	
Date of Birth (dd-mm-yy):	
PHN:	**Male** ○ **Female** ○ **Non-Binary** ○

CARE MODEL
Please choose one of the following: ☐ Family will travel to Nanaimo for medical assessment by Shapedown physician ☐ Shared Care Model for medical assessment (comprehensive physical examination to be done by referring physician or nurse practitioner in collaboration with Shapedown 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:	
Address:	
Primary Phone: □ Cell □ Home	**Alternate Phone:**
Email Address:	
Parent/Guardian 2 Name:	
Address (if different from Parent 1):	
Primary Phone: □ Cell □ Home	**Alternate Phone:**
Email Address:	
Parent/Guardian aware of referral and has given consent to be contacted? □ Yes □ No	

ANTHROPOMETRICS			
Date of Measurements:			
Height (cm):	**Weight (kg):**	**BMI:**	**Blood Pressure:**
Please attach all available growth charts and data. Please note that to be eligible for the program, child/teen must have BMI>97th %ile or BMI>85th %ile with comorbidities.			

CLINICAL CONCERNS (check all that apply)

Is your patient known to have any of the following?

□ BMI >97th %ile
□ Hypertension/Prehypertension
□ Dyslipidemia
□ Diabetes/Prediabetes/Insulin resistance
□ Sleep disordered breathing/Obstructive sleep apnea
□ Weight related musculoskeletal pain
□ PCOS
□ Depression/Anxiety/Mental health concerns
□ Weight-based bullying
□ Other (please describe):

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

1. **Family Medical History (check all that apply)**

□ Excess adiposity
□ Hypertension
□ Dyslipidemia
□ Gestational diabetes
□ Types 2 Diabetes/Insulin resistance
□ Obstructive Sleep Apnea
□ Early cardiovascular disease (males <55, females <65)
□ PCOS
□ Disordered eating: _____
□ Cancer: _____
□ Other (please describe): _____

2. **Family readiness for the Shapedown BC Virtual Program**

Expressed interest in being referred for further assessment and assistance with healthy living habits? □ Yes □ No (please describe): _____

Please help us to assess whether this patient and their family may have significant challenges in a virtual group program:

- Does the family have access to stable internet connection and devices that support videoconferencing? □ Yes □ No (please describe): _____
- Does the child have 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.: mental health issues, family conflict, food insecurity, other)? □ No □ Yes (please describe): _____
- The program is currently available in English only at this site. Is at least one parent/caregiver able to speak, write and understand English in a discussion-based group setting? □ Yes □ No

3. **Additional Comments – We value any further insight you may have into this family's strengths and challenges.**

Physician/Nurse Practitioner Information	
Referring Practitioner:	**Practitioner Number:**
Specialty:	
Address:	
Phone:	**Fax:**
Primary Care Provider (if different):	**Practitioner Number:**
Address:	
Phone:	**Fax:**

Please fax the completed referral form to: Shapedown BC Virtual Program 236-429-3635