

**Lower Mainland SHAPEDOWN BC
Physician Referral Form**



(please print clearly or fill in electronically and indicate which program you are requesting)

DATE: _____

LOWER MAINLAND LOCATIONS (Select One)	LANGUAGE OF DELIVERY	CONTACT INFORMATION
<input type="checkbox"/> Centre for Healthy Weights-Shapedown BC BC Children's Hospital, Vancouver	English	Fax: 604-875-2388 Phone: 604-875-2345 Ext.5984
<input type="checkbox"/> Fraser Health Healthy Weights Program-Shapedown BC Langley/Surrey	English	Fax: 604-514-7410 Phone: 604-514-6000 ext. 742669
<input type="checkbox"/> Fraser Health South Asian Program-Shapedown BC Langley/Surrey	Punjabi	Fax: 604-514-7410 Phone: 236-332-3786
<input type="checkbox"/> Shapedown BC Program in Chinese Richmond Public Health, Richmond	Cantonese Mandarin	Fax: 604-233-3198 Phone: 604-233-3129

CHILD INFORMATION	
Name:	
Date of Birth (dd-mm-yr):	
PHN:	Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/>

FAMILY INFORMATION		
Mother's Name:	DOB:	
Father's Name:	DOB:	
Legal Guardian's Name (please state relationship):		
Guardianship Status:		
<input type="checkbox"/> Lives with both parents/Married/Common Law (please fill out contact information for both guardians)		
<input type="checkbox"/> Joint Guardianship (please fill out contact information for both guardians)		
<input type="checkbox"/> Sole Guardianship (please fill out contact information for the sole guardian)		
<input type="checkbox"/> Other, please specify: _____		
Parent/Guardian 1 Address:		
Phone Home:	Cell:	Work:
Email Address:		
Parent/Guardian 2 Address (if different from Parent 1):		
Phone Home:	Cell:	Work:
Email Address:		

REASON FOR REFERRAL

ANTHROPOMETRICS			
Current Wt:	Current Ht:	BMI:	Current BP:
Growth History (or attach growth charts)			
Date	Height (in/cm)	Weight (lbs/kg)	

MEDICAL & PSYCHIATRIC HISTORY

- All relevant consults attached (Pediatrician, Psychiatric, Psychology, Endocrine, etc)
- Recent bloodwork, imaging, diagnostic results attached
- Other:

1. Family Medical History

2. 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:

- a) Motivated and ready to make change
- b) Prepared to attend ongoing sessions
- c) Willing and able to complete the homework assignments regularly

3. 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 any issues that might impede the child’s ability to benefit from a psycho-educational group intervention (e.g.; learning /cognitive difficulties, behavioral 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-parent 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 describe):

4. Additional Comments – We value any further insight you may have into this patient’s weight problem.

Physician Information

Referring Physician:	Practioner Number:
Speciality:	
Address:	
Phone:	Fax:
Family Physician:	Practioner Number
Address:	
Phone:	Fax:

Please fax the completed referral forms to the corresponding site.

