Thunder Bay Regional Health Sciences Centre

TBRHSC
Paediatric Healthy Living Program Referral

Patient Information:

First Name: _____

Last Name: _____

Health Card Number (include Version and Expiry Date):

_____

DOB (YYYY/MM/DD): _____

Telephone: _____

Mailing Address: _____

_____

Guidelines for Use:

1. **Form to be completed by the child's health care provider.**
2. **Fax completed form to the Paediatric Healthy Living Program 807-344-7910.**
3. **Completed form is to be retained on the patient's health record.**

Additional Patient Information

Parent/Guardian Name:

Relationship to patient:

Language: | Interpreter Required: ☐ Yes ☐ No

PATIENT MUST BE 4-17 YEARS OF AGE AND MEET ONE OF THE FOLLOWING REFERRAL CRITERIA:

☐ BMI >97th percentile

OR

☐ BMI >85th percentile, plus a significant obesity-related co-morbidity such as:

- ☐ Obstructive Sleep Apnea
- ☐ Obesity-related Type II Diabetes
- ☐ Dyslipidemia
- ☐ Hypertension
- ☐ Severe psychological impairment (school absence, bullying)
- ☐ Psychiatric symptoms requiring subspecialty care (eating disorder, depression)
- ☐ Obesity-related orthopaedic problems causing functional impairment in ADL's
- ☐ Pseudotumor Cerebri
- ☐ Other, please specify:

Current Height: | Current Weight: | Current BMI:

Additional Information:

Please include any of the following with your referral if available:

☐ Health history
☐ Psychological, Neurocognitive and social information (reports or assessments)
☐ Blood work/Diagnostic Reports
☐ Previous growth charts, weight/height history

Referring Professional Information

Name: | Professional Designation:

Mailing Address: | Fax:

Telephone:

Date of Referral:

Signature:

Is Telehealth available to the patient? ☐ Yes ☐ No

If yes, please indicate Telehealth site:

TPAEDIATRIC

BMI – Body Mass Index
ADL – Activities of Daily Living