



**Pediatric
Weight
Clinic**

Patient Referral Form

(To be completed by each child/youth's physician)

Thank you for your interest in the **Pediatric Weight Clinic**. Our Patient Referral Form is the first step in enrolment in the treatment program that could help your patient experience long-lasting lifestyle changes.

Please complete all information on the form. When completed and signed, please mail or fax it to our office. Once we receive it, we will contact your patient, set up an appointment, and notify you of the outcome when the referral process is complete.

All information submitted will be handled with the strictest of confidence.

Referring Physician's Information

Physician's Name: _____ PRACID: _____

Office Address: _____

City: _____ Province: _____ Postal Code: _____

Office Phone: _____ Office Fax: _____

Physician's e-mail: _____

Patient Information

Patient's Name: _____ Gender: Male____ Female____

Mother's Name: _____ D.O.B.: ____ / ____ / ____

Father's Name: _____ dd mm yyyy

Home Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone #: _____ Work Phone #: _____ Cell #: _____

Parent's e-mail: _____

Alberta Health Care #: _____

Height: _____ Weight: _____ Body Mass Index (BMI): _____

Reason for the referral:

Please indicate any laboratory tests that have been recently performed:

Please list any other medical conditions (asthma, ADHD, etc.):

Please briefly describe what methods the patient has previously used to lose weight (eg. weight loss programs; physical activity programs):

Physician's Signature

Date

Office Use Only:

Received: _____

Pediatrician's Review: _____

Psychologist's Review: _____

Approved: _____

Patient Notified: _____

Physician Notified: _____