Central Island Healthy Lifestyles: Shapedown BC
Referral Form

#39-1925 Bowen Road
Nanaimo, BC V9S 1H1
(250) 755-7955

DATE: _____

CHILD INFORMATION

Name: _____

Date of Birth (dd-mmm-yyyy): _____

PHN: _____ **Male** ☐ **Female** ☐ **Non-Binary** ☐

FAMILY INFORMATION

Parent/Guardian Name(s): **Mother:** _____

Father: _____

Other (please state relationship:) _____

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 Address: _____

Primary Phone: _____ **Alternate:**

Parent/Guardian 2 Address (if different from Parent 1): _____

Primary Phone: _____ **Alternate:** _____

Is the Legal Guardian aware of the referral? ☐ **Has Legal Guardian given consent to contact them?** ☐

Current Wt: _____ **Current Ht:** _____ **BMI/ %ile:** _____ **Current BP:** _____

Please attach all growth data and charts ☐

MEDICAL HISTORY

- ☐ Consults attached (Pediatrician, Psychiatric, Psychology, Endocrine, etc)
- ☐ Bloodwork or investigations, imaging, diagnostic results attached

_____

_____

_____

_____

Family History:

_____

_____

_____

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

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 or family conflict)? ☐ No ☐ Yes (please describe): _____

_____

_____

Has the family expressed interest in being referred for further assessment and assistance achieving healthier habits? ☐ No ☐ Yes

_____

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

_____

_____

_____

_____

Physician Information	
Referring Physician:	**Speciality:**
Address:	**Practitioner Number:**
Phone:	**Fax:**
Family Physician:	**Practioner Number:**
Address:	**Fax:**
Phone:	

Please fax to (250) 755-7946