

**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):

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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):

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Has the family expressed interest in being referred for further assessment and assistance including nutrition and lifestyle counseling?  No  Yes (please describe):

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

**Physician Information**

<b>Referring Physician:</b>	<b>Practioner Number:</b>
<b>Speciality:</b>	
<b>Address:</b>	
<b>Phone:</b>	<b>Fax:</b>
<b>Family Physician:</b>	<b>Practioner Number</b>
<b>Address:</b>	
<b>Phone:</b>	<b>Fax:</b>

*Please fax the completed referral forms to the corresponding site.*

