CT Children's Weight Management Program

Referral Form

(Please note – this is not an Endocrine consult referral – it is a referral to a weight mgmt pgm.)

Healthy Minds • Healthy Bodies
Healthy Families • Healthy Lives

Patient Name:_____	Date of Examination: _____
Patient DOB:___/____/_____Age: _____	(within 6 months)
Phone#: Home: _____ Cell: _____	WT: _____HT: _____BP: _____
Work: _____Email: _____	BMI: _____BMI%: _____
Referring provider: _____	Medications: _____

HISTORY

1. Abnormal weight gain since age:_____years
2. Previous weight control interventions:
   - ☐ _____
   - ☐ _____
   - ☐ _____
   - ☐ _____
3. Current health or psychiatric problems other than obesity:
   - ☐ _____
   - ☐ _____
   - ☐ _____
   - ☐ _____

FAMILY'S INTEREST IN PARTICIPATING IN WEIGHT MANAGEMENT PROGRAM

- ☐ Low
- ☐ Moderate
- ☐ High

Please be sure to inform this patient/family that this visit is to enroll in a weight mgmt program

Programs:

- ☐ Fit 5 Tykes (ages 3-5); BMI<40
- ☐ T.E.A.M. Club (ages 6-9)
- ☐ Fit 5 (ages 9-18; BMI < 40)
- ☐ Fit 5 Indiv. (BMI>40)
- ☐ Bariatric (Lap Band Surgery; BMI >40)

PHYSICAL EXAM

Please check if normal:

- ☐ Constitutional (alert, not toxic, not dysmorphic, no central adiposity)
- ☐ Skin (no striae, no hirsutism, no acne)
- ☐ Eyes
- ☐ ENT
- ☐ Neck
- ☐ Thyroid
- ☐ Respiratory
- ☐ Heart
- ☐ Abdomen
- ☐ Extremities, musculoskeletal, joints
- ☐ Neurological
- ☐ Psych (normal affect & memory)

Abnormal Exam Findings: _____

- ☐ Acanthosis nigricans (mild, moderate severe)
- ☐ Other: _____

Restriction of physical activity: No Yes

REQUIRED LABORATORY TEST

Please attach copy of results (within 6 months of referral)
Please do NOT submit referral until all lab results are in.

Fasting:

- Glucose
- Cholesterol, LDL, HDL, triglycerides
- ASAT, ALAT
- TSH, free T4
- Insulin
- (25)OH Vitamin D

CHECKLIST

- ☐ Please inform the patient that this is a weight mgmt program
- ☐ This referral sheet completed
- ☐ Laboratory results attached
- ☐ Growth chart
- ☐ Insurance card copy – front & back

_____

Physician signature

Please fax this referral (along with items in above checklist) to: 860-545-9376 – Attn: Michele

9/8/11