GROWING HEALTHY KIDS SERVICE

Growing Healthy Kids in South West Sydney

NSW Government Health
South Western Sydney Local Health District

Health care practitioner referral form for children 2 - 17 years old who are above a healthy weight

Return the completed form to - Email: **SWSLHD-GHKWeightManagementService@health.nsw.gov.au** | Fax: (02) 4621 8770 | Phone: (02) 4633 0251

Referrer Details

☐ Allied Health ☐ General Practitioner

☐ Paediatrician ☐ Nursing

☐ Other:

First Name:

Surname:

Address:

Phone Number:

Email:

Client Details

First Name:

Surname:

DOB:

Gender: ☐ Male ☐ Female

Cultural background:

Parent / Carer Contact Details

First Name:

Surname:

Address:

Phone Number:

Email:

Is an interpreter required? ☐ Yes ☐ No

Specify language:

Clinical Details

Patient's Current Body Measurements

Weight (kg): Height (cm):

BMI (percentile):

Does the client have one or more known co-morbidities (Please identify below) ☐ Yes ☐ No ☐ Unsure

☐ High BP (>95%)
☐ Symptoms of obstructive sleep apnoea
☐ Joint pain or other musculoskeletal complication
☐ Acanthosis nigricans
☐ Psychological consequences
☐ Behavioural concerns
☐ Abnormality of growth
☐ Dyslipidemia
☐ Renal problems
☐ Symptoms of liver dysfunction, Non Alcoholic Fatty Liver Disease (NAFLD)
☐ Dysglycemia, Type 2 Diabetes

Please attach copies of any investigations if available:

☐ Fasting BGL ☐ FBC
☐ EUC ☐ LFT
☐ Fasting (Chol/LDL/HDL/TG) ☐ HbA1c
☐ Vitamin D ☐ TSH
☐ OGTT ☐ Sleep study
☐ Other:

Other medical concerns:

Does the child have a paediatrician? ☐ Yes ☐ No

Details:

Has the child previously been engaged in a weight management service (e.g. Go4Fun, Dietitian): ☐ Yes ☐ No

Please specify:

Patient Consent

I, ... (parent / guardian name) have discussed the referral to the Growing Healthy Kids Service with our health care professional and consent to service provision. I understand that participation in the service requires regular attendance and monitoring of progress and that measurements and progress will be recorded and used for ongoing evaluation of the clinic program.

Parent / guardian signature: Date: