 Paediatric Service

The Charles

Perkins Centre

**at the Metabolism & Obesity Service**

**Charles Perkins Centre RPA Clinic**

**Level 1, The Hub, Charles Perkins Centre, John Hopkins Drive**

**University of Sydney NSW 2006**

**Belmore Early Childcare Health Centre**

**38 Redman Parade, Belmore   
Ph: 8627 0403, Fax: 8627 0141**

A dietitian only weight management service for children and their families with overweight or obesity (a BMI-for-age ≥85th-99th percentile) without or with metabolic disorders that require ongoing monitoring from a paediatrician

**Please fax to: 8627 0141 or email: kyra.sim@health.nsw.gov.au**

**PATIENT DETAILS**

|  |  |
| --- | --- |
| Surname: | First name: |
| Date of birth: | Sex: □ Male □ Female □ Other |

**PARENT / CARER CONTACT DETAILS**

|  |  |
| --- | --- |
| Name: | |
| Home phone: | Mobile phone: |
| Home address: | |
|  | |
| Interpreter required: □ Yes □ No | If yes, specify language: |

Internet access: □ Yes □ No

**PATIENT AGREEMENT**

|  |  |
| --- | --- |
| I, …………………….…………………………. (parent/guardian name) have discussed the referral to the Healthy Families Service with our health professional and consent to participate. I understand that participation in the clinic 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) | |
|  |  |

**CLINICAL DETAILS**

|  |  |  |
| --- | --- | --- |
| Weight: | | Height: |
| BMI: | BMI centile: | |
|  | | |
| Investigations if already performed; please attach any relevant pathology details  Not needed routinely, please attach results if applicable.  (Consider fasting BSL, insulin, TG, cholesterol +/- vit D, iron studies, LFTs.) | | |
|  | | |
|  | | |
|  | | |
| Other significant medical or social history:  □ Asthma □ Glucose dysregulation □ Insulin resistance □ Dyslipidaemia □ HTN  □ Neurodevelopmental disorder (e.g. ADHD, ASD), please specify □ Other, please specify | | |
|  | | |
|  | | |

**REFERRING DOCTOR/ HEALTH PROFESSIONAL DETAILS**

|  |  |
| --- | --- |
| Name: | |
| Clinical role: □ Paediatrician □ GP □ Allied health □ Nurse □ Other, please specify | |
|  | |
| Provider number: (if applicable) Email: | |
| Address: | |
| Phone: | Fax: |
| Signature: | Date: |
| Paediatrician/GP details: (if applicable) |  |
|  |  |
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