**John Hunter Children’s Hospital Weight Management Service Referral Form**

**Please fax completed form to the Referral Information Management System 02 4922 3904**

**Dr Elizabeth Percival, JHCH Weight Management Service,**

**Patient details:**

|  |  |  |
| --- | --- | --- |
| Given Name: | | Surname: |
| DOB: | □ Male □ Female | □ Aboriginal □ Torres Strait Islander |
| Medicare Number: | | |

**Parent/Carer Contact Details:**

|  |  |
| --- | --- |
| Name: | Relationship to Child: |
| Contact Ph: | Email address: |
| Address: | |
| Is an interpreter required? □ Yes □ No If Yes, specify language:  Is assistance required to complete forms □ Yes □ No | |

**Clinical details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Weight: kg | | | Height: cm | | |
| BMI: kg/m2 | | |  | | |
| □ High BP  (>95% - see link below) | □ Symptoms of obstructive sleep apnoea | | □ Joint pain or other musculoskeletal complications e.g. SCFE | | □ Acanthosis nigricans |
| □ Psychosocial consequences  Specify: | | | □ Behavioural problems  Specify: | | |
| Other significant medical/social history: | | | | | |
| **Please attach copies of the following investigations (essential for 7-17 years):** | | | | | |
| □ Fasting BGL | □ FBC | | □ EUC | | □ LFT |
| □ Fasting lipid profile  (Chol/LDL/HDL/TG) | □ HbA1c | | □ Vit D | | □ TSH |
| **Please attach copies of the following investigations if available:** | | | | | |
| □ OGTT | | □ Sleep study | | □ Other: | |
| Has the child/family had previous engagement with a weight management service e.g Go4Fun or dietitian  □ Yes □ No Please specify: | | | | | |

**Patient Agreement**

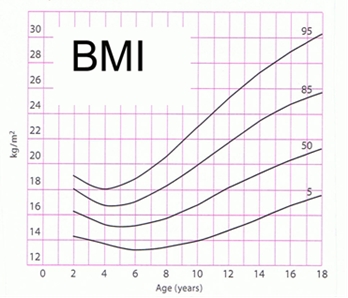
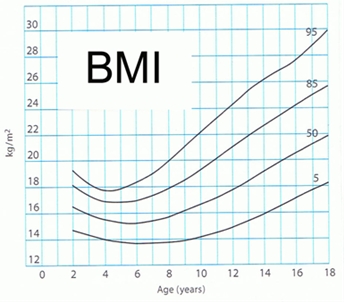
I, …………………………………............................(parent/guardian signature) have discussed the referral to John Hunter Children’s Hospital Weight Management Service with our doctor and consent to participate. I understand that participation in the clinic requires regular attendance and monitoring of progress and that measurements and progress will be recorded and used for ongoing evaluation of the program.

**Referring Doctor Details**

|  |  |
| --- | --- |
| Name: | Provider Number: |
| Address: | Phone: |
| Signature: | Date: |

**BMI centile charts** taken from CDC Growth charts.

BMI = weight in kg ÷ (Height in metres)2

Blood pressure percentile information available at:

<http://www.rch.org.au/clinicalguide/guideline_index/hypertension/>