Trillium Health Partners
Better Together

Last Name: _____ First Name: _____

Date of Birth (DD/MM/YYYY): _____/_____/_____

Health card #: _____

MRN #: _____

CSN #: _____

THP use only

Affix patient encounter label here/complete all fields if label not available.

THE KIDFIT HEALTH AND WELLNESS CLINIC
Referral Ages: 2- 17 years

KidFit is a paediatric health and wellness clinic, for children who meet the following criteria:

- **Ages 2 to 17 years (Due to the length & nature of the program, referrals must be received prior to child's 17th birthday)**
- **BMI of greater than, or equal to the 95th percentile (CDC Growth Chart).**
- **BMI of greater than, or equal to the 97th percentile (WHO Growth Chart of Canada).**
- **MUST have a current growth chart**
- **MUST have recent (within 3 months) laboratory testing including lipid profile, hemoglobin A1c, glucose and ALT**

Please fax completed: referral form with the above documents to KidFit Clinic at: Fax: 905-804-7741 or call 905-848-7580

PATIENT DEMOGRAPHICS:

Last Name: _____ First Name: _____ Date of Birth (DD/MM/YYYY): _____/_____/_____

Health Card #: _____ Legal Sex: ☐ Female ☐ Male ☐ Non-Binary ☐ Unknown ☐ X

Address: _____ City: _____ Province: _____ Postal Code: _____

Telephone number: _____ Mobile number: _____ Email Address: _____

Anthropometry

Date of Assessment *(yyyy-mm-dd):*	Weight: kg	Height: cm	BMI for Age Percentile *(Ages 2-17 years):*	
☐ All Growth Charts Attached *(mandatory):*			☐ CDC	☐ WHO

Co-Morbidities

(Please check all that apply)

- ☐ Prehypertension
- ☐ Hypertension
- ☐ NAFLD (ALT > 1.5 – 2.0x normal, ultrasound with mild to moderate fatty infiltration of the liver)
- ☐ LDL-C > 3.4 mmol/L
- ☐ non-HDL-C > 4.1 mmol/L
- ☐ HDL-C < 1.03 mmol/L
- ☐ TG > 1.5 mmol/L
- ☐ Impaired glucose tolerance (7.8 mmol/L – 11.0 mmol/L)
- ☐ Impaired fasting glucose (6.1 mmol/L– 6.9 mmol/L)
- ☐ Pre-diabetes (A1c 6.0% – 6.4%)

☐ Other *(i.e., other co-morbidities or underlying medical conditions)*

Please specify:

_____

_____

_____

Please include all labs, imaging, growth charts etc.
Appointments will not be booked until all required information has been provided. Please note, while patients are awaiting elective consultation, KidFit cannot accept responsibility for their health care until the patient has been seen. As their referring professional, you remain responsible for all their medical related care.

REFERRING PROVIDER:

Name of Referring Provider (Last Name, First Name- as listed in CPSO): _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Phone number: _____ Fax number: _____ CPSO #: _____ Billing (OHIP) #: _____

Signature: _____ Date: _____