Trillium Health Partners

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**

Please fax completed referral form, all growth charts and any pertinent blood work from the past 12 months to KidFit Clinic at:
Fax: 905- 813- 3576 or call 905- 813- 1100 x3379 with any questions.

Referrer Information

Name of Referring Source (MD):	**Billing Number:**	**Office Phone Number:**	**Office Fax Number:**
Name of Family Physician:	**Office Phone Number:**	**Office Fax Number:**	

Client Information

Last Name:		**First Name:**	**Middle Initial:**
☐ **Female** ☐ **Male** ☐ **Alternative**	**Age:** **Grade:**	**Date of Birth** *(yyyy- mm- dd):*	**Health Card Number/Version Code:**
Address:		**City:**	**Postal Code:**
Parent/ Guardian Name *(last, first):*		**Relationship to Client:**	**Language Spoken:**
			Interpreter Required: ☐ **Yes** ☐ **No**
Home Phone Number:		**Alternate Phone/Cell Number:**	**Work Phone Number:**

Anthropometry

Date of Assessment *(yyyy- mm- dd):*	**Weight:** **kg**	**Height:** **cm**	**BMI for Age Percentile** *(Ages 2- 17 yrs):*
All growth charts attached *(mandatory):* ☐			☐ **CDC** ☐ **WHO**

Co- Morbidities

(Please check all that apply)

- ☐ **Hypertension**
- ☐ **Dyslipidemia**
- ☐ **Pre- diabetes**
- ☐ **Type 2 Diabetes**
- ☐ **Disordered Eating**
- ☐ **Non- alcoholic Fatty Liver Disease**
- ☐ **Gallbladder Disease**
- ☐ **Blount's Disease**
- ☐ **Slipped Capital Femoral Epiphysis (SCFE)**
- ☐ **Obstructive Sleep Apnea**
- ☐ **Gastroesophageal Reflux**
- ☐ **Polycystic Ovary Syndrome**
- ☐ **Depression**
- ☐ **Anxiety**
- ☐ **ADHD**
- ☐ **Neurodevelopmental Disorders**

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

_____
_____
_____
_____

Signature

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.

Signature of Referring MD: _____ **Date:** _____

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