

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Date of Birth (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Health card #: \_\_\_\_\_  
 MRN #: \_\_\_\_\_  
 CSN #: \_\_\_\_\_

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

## THE KIDFIT HEALTH AND WELLNESS CLINIC REFERRAL

**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  $\geq$  to the 97th percentile (WHO Growth Charts for Canada).
- **MUST** have a current growth chart
- **MUST** have recent (within 3 months) **ABNORMAL** laboratory testing including lipids, hemoglobin A1c, glucose and ALT levels as listed below in CO-MORBIDITIES.

**Please fax completed: referral form with the above documents to KidFit Clinic at: Fax: 905-804-7741 or call 905-848-7580 x2203 with any questions.**

### 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: \_\_\_\_\_

<b>Anthropometry</b>	Date of Assessment (yyyy-mm-dd): _____	Weight: _____ kg	Height: _____ cm	BMI Percentile (Ages 2-16 years): _____
	Blood Pressure: Systolic: _____ Diastolic: _____ mmHg			<input type="checkbox"/> WHO
<b>Co-Morbidities</b>	(Please check all that apply)			<input type="checkbox"/> Other (i.e., other co-morbidities or underlying medical conditions) Please specify: _____ _____ _____
	<input type="checkbox"/> Elevated blood pressure <input type="checkbox"/> MASLD (formally NAFLD) (ALT > 1.5 – 2.0x normal or ultrasound with mild to moderate fatty infiltration of the liver) <input type="checkbox"/> LDL-C > 3.4 mmol/L <input type="checkbox"/> non-HDL-C > 4.1 mmol/L <input type="checkbox"/> HDL-C < 1.03 mmol/L <input type="checkbox"/> TG > 1.5 mmol/L if > 10 years old or > 1.1 if < 9 years old			
<p><b>Please include all labs, imaging, growth charts, etc.</b>  <b>Appointments will not be scheduled until all required information has been provided. Please note that while patients are awaiting elective consultation, we cannot accept responsibility for their health care until they have been seen. As their referring professional, you remain responsible for all their medical-related care.</b></p>				

### 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: \_\_\_\_\_

