CHILDREN'S EXERCISE AND NUTRITION CENTRE

Please fax completed forms to:

905-385-5033

Contact booking desk at **905-521-2100 x 76990** for any further questions

Date of Referral _____

Patient Information

Patient Name: _____

DOB: _____ __Male __Female

Health Card # _____(OHIP)

Address: _____

_____ Postal Code: _____

Telephone:

Family Physician _____

Referring Physician Information

Name:_____
Address:

Postal Code:

Telephone:

Fax:
E-mail (Optional):
Physician Billing #: _____

Signature: _____

[ ] Weight Management [ ]Pediatric Lipid Clinic [ ] Exercise Medicine

Medical Conditions (check all that apply)

□ Acanthosis Nigricans/ Hyperinsulinemia	□ Dyslipidemia	□ Microalbuminuria
□ ADHD/Neuro dev. disorder	□ Eating Disorder	□ Obstructive Sleep Apnea
□ Arthritis or related	□ Fatty Liver/Gallbladder Disease	□ Polycystic Ovarian Syndrome
□ Asthma	□ GERD	□ Pseudotumor Cerebri
□ Cancer	□ Hemophilia	□ SSCFE/Blount's
□ Cardiac	□ Hypertension	□ Spina Bifida
□ Cerebral Palsy	□ IBD	□ Type 1 Diabetes
□ Cystic Fibrosis	□ Kidney Disease	□ Type 2 diabetes
□ Depression/Anxiety	□ Medication induced weight gain	□ Family hx premature coronary artery disease
□ **Other** _____	□ Mental Health (other) _____	

Details of Referral:

_____

_____

_____

Medications:

_____

Additional Information

Previous weight management interventions (if applicable):

□ No intervention □ Community based program □ Primary care counselling □ Dietitian □ Multidisciplinary counselling

Interpreter Required? □ Yes □ No **Primary Language:** _____

Required Investigations and Documents (Please Attach)

Anthropometry: Date assessed (y/d/m)_____ Weight: _____kg Height: _____cm BMI%:_____

□ Growth chart (if available) □ Fasting Lipid Profile □ Glucose □ Liver enzymes □ HbA1c □ TSH □ other