Last Name *(Legal)*		First Name *(Legal)*	
Preferred Name ☐ Last ☐ First		DOB *(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN	
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X) ☐ Unknown			

Provincial Pediatric Weight Management Referral

(Ages 2-17 years with a BMI greater than 85th percentile)

Referrals are accepted from Physicians and Nurse Practitioners. Services are available across the province at AHS and Covenant Health sites.

Submit completed form to Alberta Health Services Central Access at **Fax**: 780.735.3553 or **Toll Free Fax** *(in Alberta)*: 1.866.979.3553.

Missing or incomplete information **will result** in delays.

Two referral options are available: Assess child/family preference for treatment option, stage of change, root causes and co-morbidities to ensure referral to most appropriate level of care. Parent/guardian participation is required.

Type of Referral *(Check one)*

☐ **Outpatient Dietitian Counselling**

Registered dietitians trained in pediatric weight management are available across the province. Program includes screening and basic intervention in physical activity, sleep hygiene, sedentary time and more intensive intervention in nutrition. Dietitians may refer to and coordinate care with other healthcare providers and services.

OR

☐ **Specialty Care** *(Pediatric Centres for Weight and Health)*

Clinics are located in Edmonton and Calgary with distance options available. This is a comprehensive assessment and intervention involving specialist physicians and an interdisciplinary team (e.g., nurse, dietitian, psychologist, exercise specialist and social work). These teams help identify and manage co-morbidities and support children/families with complex health care needs.

Name of Referring Source *(MD or NP)*	Phone Number	Fax Number	PRACID
Name of Primary Care Provider *(if applicable)*	Phone Number		Fax Number

Client Information

Last Name	First Name	Sex ☐ Female ☐ Male	Date of Birth *(yyyy-Mon-dd)*
Personal Healthcare Number	Parent/Guardian Name *(First, Last)*		Relationship to Client
Is Parent/Guardian aware of referral? ☐ Yes ☐ No	Address		Phone Number
Alternate Number	Language Spoken		Is interpreter required? ☐ Yes ☐ No

Anthropometry

Date Assessed *(yyyy-Mon-dd)*	Weight *(kg)*	Height *(cm)*	BMI *(kg/m²)*	BMI for Age Percentile

Most recent growth chart attached *(preferred)* ☐ Yes ☐ No

Co-morbidities

☐ Hypertension	☐ Obstructive Sleep Apnea	☐ Dyslipidemia
☐ Polycystic Ovary Syndrome	☐ Type 2 Diabetes/IGT	☐ Depression/Anxiety
☐ Medication Induced Weight Gain	☐ Acanthosis Nigricans/Hyperinsulinemia	☐ Disordered Eating
☐ Fatty Liver/Gallbladder Disease	☐ ADHD/Neurodevelopmental Disorders	☐ IIH

Other Client/Family Information