Soldiers' MEMORIAL HOSPITAL Orillia

CHOOSING HEALTHY ACTIONS TOGETHER (CHAT) REFERRAL FORM

Fax: (705) 330-3229 Telephone: (705) 325-2201 EXT.6154

PATIENT INFORMATION

Name: _____ DOB: _____ (YY/MM/DD)

HC#: _____ Version: _____ MRN:_____

Address: _____ City: _____ Postal: _____

Telephone #: _____ Other #: _____

REFERRAL INFORMATION

☐ **Patient meets criteria for Paediatric Bariatric Clinic (BMI or wt for ht >85th percentile)**

Current: Weight: _____ Height: _____ BMI: _____

Comorbidities:

☐ Sleep Apnea

☐ Hypertension

☐ Hyperlipidemia

☐ PCOS

☐ Type 2 Diabetes

☐ Other:_____

List any other medical conditions (asthma, ADHD, behavioral problems, etc.):

Current Medications:

Please ensure client has completed the blood requisition form ☐ Yes ☐ No

Please include copy of WHO Growth Chart: ☐ Yes ☐ No

Referring Physician Name:_____ Phone Number:_____

Signature:_____ **CPSO:**_____ **Date:**_____

OFFICE USE ONLY:

Referral Received: _____ Paediatrician: _____