Vancouver CoastalHealth

generationhealth Healthy Living Programs for Families | Clinic

Generation Health Clinic - Program in Chinese Referral Form

www.generationhealth.ca

Date:

CHILD INFORMATION	
Name:	Date of Birth (yyyy-mm-dd):
PHN:	Male ❍ Female ❍ Intersex ❍

FAMILY INFORMATION

Guardianship Status:

❍ Lives with both parents/Married/Common Law
(please fill out contact information for both guardians)

❍ Joint Guardianship
(please fill out contact information for both guardians)

❍ Sole Guardianship
(please fill out contact information for the sole guardian)

❍ Other *(please specify):* _____

Parent/Guardian 1 Name:	Parent/Guardian 2 Name:
Address:	Address:
City: Postal Code:	City: Postal Code:
Primary Phone: ❍ Cell ❍ Home	Primary Phone: ❍ Cell ❍ Home
Alternate Phone:	Alternate Phone:
Email Address:	Email Address:

Family ready or interested in making healthy living changes: ❍ Yes ❍ No

Parents/Guardians aware of referral and have given consent to be referred and contacted (by phone call, email and/or text) ❍ Yes ❍ No	**At least one parent/caregiver able to speak, write and understand English in a discussion-based group setting** ❍ Yes ❍ No

ANTHROPOMETRICS *(please attach all available growth charts & data)*

Date of Measurements:

Height (cm):	Weight (kg):	BMI:	Blood Pressure:

CLINICAL CONCERNS *(Please check all that apply)*

Reason for Referral: ❍ BMI for age >97th %ile
❍ BMI for age >85th %ile with or at high risk of developing complications (see list below)

Complications:
- ❍ Insulin resistance/Prediabetes/Diabetes
- ❍ Dyslipidemia
- ❍ Depression/Anxiety
- ❍ Obstructive sleep apnea/sleep disordered breathing
- ❍ Metabolic dysfunction-associated steatotic liver disease (MASLD)
- ❍ Musculoskeletal pain
- ❍ Prehypertension/Hypertension
- ❍ PCOS

Other concerns:
- ❍ Neurodiversity (e.g. ASD, ADHD)
- ❍ Socio-emotional concerns
- ❍ Behavioural problems
- ❍ Psychiatric concerns
- ❍ High risk family history
- ❍ Weight-based bullying
- ❍ Other (please describe):

_____

_____

Exclusion criteria: Children/teens must be able to participate in a group program. The program is **not** appropriate for those with:
- an active eating disorder
- acute mental health concerns (e.g., active self-harm/suicidal ideation, mental health crisis)
- uncontrolled behavioural problems (e.g., aggressive behaviour, flight risk, verbal harassment)

BRITISH COLUMBIA

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PAST MEDICAL HISTORY
Please attach all available consults, recent bloodwork, imaging, diagnostic results.

FAMILY MEDICAL HISTORY
Please detail:

HOME ENVIRONMENT
Significant stressors affecting this child/family: ❍ Mental health/addictions concerns ❍ Family conflict ❍ Food insecurity ❍ Other (please describe):

PHYSICIAN/NURSE PRACTITIONER INFORMATION	
Referring Provider:	MSP Number:
Specialty:	
Address:	
Phone:	Fax:
Primary Care Provider:	MSP Number:
Address:	
Phone:	Fax:

Please fax the completed referral form to Richmond Place: 604-233-3198.
For any questions, please call 604-233-3129.