Eastern Health

Janeway Lifestyle Program

Referral for Consultation

for children 2 to18 years of age

Please complete, sign and send to:

Lifestyle.Program@easternhealth.ca

AS4470 0019 05 2015

Incomplete applications will not be processed.

Date: DD/MONTH/YYYY

☐ Eastern Health ☐ Central Health

☐ Western Health ☐ Labrador-Grenfell Health

Patient Information:

HCN: _____

Name: _____ Date of Birth: DD/MONTH/YYYY Age: _____

Height: _____cm **Weight: _____ kg** **BMI: _____** **% _____**

1st Parent/Guardian's Name: _____

Address: _____

Phone: _____ Alternate Phone: _____

Postal Code: _____ Email: _____

2nd Parent/Guardian's Name: _____

Address: _____

Phone: _____ Alternate Phone: _____

Postal Code: _____ Email: _____

Reason for Consultation Referral (please check one or more):

☐ BMI greater than 95th percentile ☐ Abnormal lipid profile ☐ Fatty liver ☐ Hypertension

☐ Signs/symptoms of Insulin resistance (e.g. Impaired Glucose Tolerance, Type 2 Diabetes, PCOS, acanthosis nigricans)

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

Are you aware of any obstacles that would impede group treatment (ages 6-18 only)? ☐ Yes ☐ No

If yes, please explain: _____

Add any additional information you feel would be helpful to the team at the Janeway Lifestyle Program:

Please note: Lab work is **not** required prior to referral as this will be completed as part of medical workup.

Referring Health Care Professional's Information:

Name: _____ Profession: _____

Office Phone: _____ Email: _____

Address: _____ Postal Code: _____

If you are unsure of any part of this referral form or have questions, please call 1-709-777-4387