Trillium Health Partners
Better Together

Last Name: _____ First Name: _____

Date of Birth (DD/MM/YYYY): _____/_____/_____

Health card #: _____

MRN #: _____

CSN #: _____

THP use only

Affix patient encounter label here/complete all fields if label not available.

THE KIDFIT HEALTH AND WELLNESS CLINIC REFERRAL

KidFit is a paediatric health and wellness clinic, for children who meet the following criteria:

- **Ages 2 to 16 years (Due to the length & nature of the program, referrals must be received prior to child's 16th birthday)**
- **BMI of ≥ to the 97th percentile (WHO Growth Charts for Canada).**
- **MUST have a current growth chart**
- **MUST have recent (within 3 months) ABNORMAL laboratory testing including lipids, hemoglobin A1c, glucose and ALT levels as listed below in CO-MORBIDITIES.**

Please fax completed: referral form with the above documents to KidFit Clinic at: Fax: 905-804-7741 or call 905-848-7580 x2203 with any questions.

PATIENT DEMOGRAPHICS:

Last Name: _____ First Name: _____ Date of Birth (DD/MM/YYYY): _____/_____/_____

Health Card #: _____ Legal Sex: ☐ Female ☐ Male ☐ Non-Binary ☐ Unknown ☐ X

Address: _____ City: _____ Province: _____ Postal Code: _____

Telephone number: _____ Mobile number: _____ Email Address: _____

Anthropometry	Date of Assessment *(yyyy-mm-dd):*	Weight: kg	Height: cm	BMI Percentile *(Ages 2-16 years):*
	Blood Pressure: Systolic: Diastolic: mmHg			☐ WHO
Co-Morbidities	(Please check all that apply) ☐ Elevated blood pressure ☐ MASLD (formally NAFLD) (ALT > 1.5 – 2.0x normal or ultrasound with mild to moderate fatty infiltration of the liver) ☐ LDL-C > 3.4 mmol/L ☐ non-HDL-C > 4.1 mmol/L ☐ HDL-C < 1.03 mmol/L ☐ TG > 1.5 mmol/L if > 10 years old or > 1.1 if < 9 years old ☐ Impaired glucose tolerance (7.8 mmol/L – 11.0 mmol/L) ☐ Impaired fasting glucose (6.1 mmol/L– 6.9 mmol/L) ☐ Pre-diabetes (A1c 6.0% – 6.4%)			☐ Other *(i.e., other co-morbidities or underlying medical conditions)* Please specify: _____ _____ _____
	Please include all labs, imaging, growth charts, etc. Appointments will not be scheduled until all required information has been provided. Please note that while patients are awaiting elective consultation, we cannot accept responsibility for their health care until they have been seen. As their referring professional, you remain responsible for all their medical-related care.			

REFERRING PROVIDER:

Name of Referring Provider (Last Name, First Name- as listed in CPSO): _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Phone number: _____ Fax number: _____ CPSO #: _____ Billing (OHIP) #: _____

Signature: _____ Date: _____