NEPEAN FAMILY METABOLIC HEALTH SERVICE (NFMHS)

KIDS FIT 4 FUTURE CLINIC REFERRAL – AGES 2-15 YEARS

Please note that if you have a patient aged 16 years or above, please refer them to the Adult Healthy Weight Clinic. If you believe that the patient needs an urgent review, then contact the service by telephone directly.

In addition to this referral, please provide:

- ✓ *an up-to-date medication list*
- ✓ *a medical summary*
- ✓ *any other relevant documents*

THIS IS AN INDEFINITE REFERRAL (please delete if not applicable)

Please tick one of the boxes:

☐ **A/Prof Gary Leong** ☐ **Kids Fit 4 Future Clinic** ***(any doctor available on the day)***

Dear Doctor,

Thank you for seeing _____(name), of _____

_____ (address), D.O.B ___/___/___. Their primary contact(s) is/are _____.
Relationship(s) to patient _____. Contact phone number(s) _____.

Date of measure: _____ Weight: _____kg Height: _____cm

Calculated BMI: _____kg/m^2 Waist Circumference: _____ cm BP: _____ mmHg

Is the patient of Aboriginal/ Torres Strait Islander background? (Please circle)

Does the patient require an interpreter? **YES/NO** (If yes, specify language):_____

Does the patient have a parent/carer who can read and write? **YES / NO**

Parent/Carer(s) at home: □ Mother □ Father □ Other (details :_____)

Mother's name_____ AGE_____ estimated BMI (kg/m^2) □ < 30 □ 30 to < 40 □ ≥ 40

Father's name_____ AGE_____ estimated BMI (kg/m^2) □ < 30 □ 30 to < 40 □ ≥ 40

Is the patient and their family *willing and capable* of engaging with an obesity service and do they understand that this will usually involve attending group education sessions*?* **YES / NO**
(Please note that declining group sessions may delay and/or prevent initiation of treatment).

Is there potential for this patient to have problems attending groups and/or appointments at Nepean Hospital due to certain behaviours (e.g. head banging, shouting, hitting etc.)? **YES / NO**

Have FACS been involved with this patient? **YES / NO** Have FACS requested this referral? **YES / NO / NA**

Have there been any problems in the family related to (tick all that apply):

□ Drug Addiction? □ Domestic Violence? □ Neglect? □ Physical abuse? □ Sexual abuse? □ Mental Illness?

If you have indicated yes/ticked any of the above, please provide details and/or attach any relevant documents

Name of Doctor: _____ Signature: _____

Practice Address _____
Practice Phone Number: _____ Practice Fax Number: _____ Date: ___/___/___

Nepean Family Metabolic Health Service, Level 5 South Block, Nepean Hospital
PO Box 63 Penrith, NSW 2751
Ph. **(02) 4734 4533** Fax **(02) 4734 1920**
NBMLHD-FamilyMetabolicHealthService@health.nsw.gov.au
For appointments please fax or email this referral to the above contacts

Have you referred the patient to Go4Fun® if they are aged 7-13 years? YES / NO
https://go4fun.com.au/register

Have you referred the parents to GetHealthy®? YES / NO
https://www.gethealthynsw.com.au/get-started/

For more information, please visit the healthykids for professional's website:
https://pro.healthykids.nsw.gov.au/resources/

Consider completing online Weight4Kids modules for healthcare providers:
https://weight4kids.learnupon.com/users/sign_in?next=%2Fdashboard

- **Please provide supporting evidence for any co-morbidities (e.g. blood tests, liver biopsy reports, sleep study reports, specialist letters), as this will help us to triage your patient so that they can be seen in an acceptable timeframe.**
- **Attending the NFMHS requires a time commitment and patient/ carer motivation to make changes. Patients and their parents/carers need to be well enough to attend multiple appointments, including groups.**
- **This referral will be assessed by our medical team to determine suitability and you will be notified if the patient cannot be accepted.**

Age ≥ 2 and <16 years	**BMI > 95th Centile by BMI chart (link below)** https://www.rcpch.ac.uk/sites/default/files/2018-03/boys_and_girls_bmi_chart.pdf ☐
	Please identify any *obesity related co-morbidities or risk factors*: Type 2 diabetes/prediabetes/severe insulin resistance (please circle relevant option) ☐ Family history of early onset type 2 diabetes or ischaemic heart disease (first degree relative at < 50 years of age or ≥ 3 2nd degree relatives < 50 years of age) ☐ Hypertension ☐ Dyslipidaemia ☐ Sleep disordered breathing (Details: _____) ☐ NAFLD/NASH ☐ Specific end-organ condition directly related to obesity, e.g. Idiopathic intracranial hypertension (Details: _____) ☐ PCOS with oligoamenorrhoea (≤ 9 periods/year)/biochemical hyperandrogenism ☐ Orthopaedic issue (Details: _____); Pain? Y / N ☐ Behavioural disorder: Autism/ODD/ADHD/other (Details: _____ _____) ☐ Mental health: Anxiety/ Depression/ Schizophrenia/ Bipolar/ Other (Details: _____) ☐ Eating disorder (bulimia/ BED/ EDNOS/ other (Details: _____) ☐ Frequent presentations to hospital in last 12 months with obesity related condition (Details: _____) ☐ On waitlist for major surgery (cardiothoracic, abdominal, orthopaedic, neurosurgical) and required to lose weight to reduce operative risk ☐ Another family member being seen at NFMHS (Please provide name(s): _____) ☐ Other (Details: _____) ☐