MISSION CHILDREN'S HOSPITAL

CHILD WEIGHT MANAGEMENT PROGRAM REFERRAL

11 Vanderbilt Park Drive, Asheville, NC 28803
Registration: (828) 213-1733 Fax: (828) 213-1742

PLEASE COMPLETE AND FAX TO (828) 213 1742

Patients Name: _____ _____ _____ DOB: _____ Age: _____
(First) (MI) (Last)

Mailing Address: _____

Mother's Name: _____ _____ Father's Name: _____ _____
(Guardian) (First) (Last) (Guardian) (First) (Last)

Home Phone: (_____) _____ Mother's Cell Phone: (_____) _____

Mother's Work Phone: (_____) _____ Father's Work Phone: (_____) _____

Father's Cell Phone: (_____) _____

Name of Other Contact _____Other Contact Phone: (_____) _____ Relationship: _____

Referring Healthcare Provider: _____

Referring Provider Practice: _____

Office Phone: (_____) _____ Office Fax: (_____) _____

Primary Care Physician: _____

Primary Care Physician Practice: _____

Office Phone: (_____) _____ Office Fax: (_____) _____

GUARDIANS MUST BRING PROOF OF GUARDIANSHIP TO THE APPOINTMENT

Name of Insurance: _____ Medicaid/Carolina Access Provider Number: _____
*****PLEASE SEND COPY OF INSURANCE CARD (FRONT AND BACK)*****

Is an interpreter needed? YES ☐ NO ☐ If yes, language_____

Date of measurements: _____ Height: _____ Weight: _____ BMI %: _____

*****Please attach any labs that have been checked over the past 6 months and growth chart history*****

Is it safe for child to participate in physical activities, including running and jumping?
Yes ☐ No ☐ Restrictions: _____ _____

Is child able to participate in group activities and focus attention for at least 30 minutes? Yes ☐ No ☐

Medications: _____

_____

Referral to program includes visits with MD, LCSW, and RD for evaluation and ongoing treatment as needed.

Referring Physician Office contact name: _____ Phone Number: (_____) _____

Referring Provider Signature: _____ **Date**: _____