

**Child Healthy Weight Service – Referral Form**

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| **Child’s details:** |
| Child’s name:  |
| Date of birth:  | CHI |
| School/year: |
| Parent/Carer’s name : |
| Address: |
| Contact number: |

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| **Referrer’s details:** |
| Name:  |
| Job title: |
| Address: |
| Contact number: |
| GP contact details: |

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| **Reason for referral** |
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| **Relevent medical condition/medicaiton**  |
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| **Child’s measurments** |
| Weight (kg)- | Weight centile- |
| Height (cm)- | Height centile- |
| BMI-  | BMI centile-  |
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| **Any known emotional difficulties (e.g. anxiety low mood, depression)?** |
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| **Any other condition which requires additional suppot (e.g. ADHD, ASD, Learning Disability)?** |
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| **Please detail any services involved (Paediatician, CAMHS, Social Work)?** |
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| **Please detail any known medical/mental health difficulities experinced by close family members (diabetes, depression, eating disorder)** |
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| **Any known communication difficulties?**  |
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| **Any other useful/appropriate information?** |
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| **Is the parent/carer in agreement with this referral?** |
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|  |
| **Referer signature** |  | **Date:** |  |

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