

**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 Date- Date taken: Date-** | | | | |
| 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 support (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:** |  |

Community Weight Management Department

Urquhart Building

City Hospital

Park Road

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