

Early Lifestyle Intervention Clinic

**REFERRAL CRITERIA:**

1. Patient is between the ages of 2 and 18.

* Yes
* No

1. Patient has a BMI > 99th %, or > 95th % with existing comorbidity (see page 3).

* Yes
* No

1. Parents/guardians are willing to commit to participate in the Early Lifestyle Intervention program.

* Yes
* No

1. Previous attempts to control or decrease weight by patient and healthcare professional (for a minimum of 3 months) have been unsuccessful. Documentation required (minimum of 3 notes from health care provider within the past 6 months).

* Yes
* No

If you answered “yes”, please check the following weight control strategies that have been attempted.

* Primary Care Physician (PCP) Intervention
* Clinician Counseling
* Motivational Interviewing
* Registered Dietitian
* Behavioral/Psychological Therapy
* Exercise Program/Physical Therapy
* Medical/Medication Management

If you answered **YES** to **ALL** of the above questions, please complete the referral form below and return it to:

Rebecca Schumacher

P :( 918)619-4366

(918)619-4400 option 2

F: (918)619-4584

If you answered **NO** to **ANY** of the above questions, your patient does not currently qualify for services from the Early Lifestyle Intervention clinic.

**PLEASE CONTINUE TO PAGE 2**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M or F (Circle One)

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship To Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION:**

**PLEASE SEND A FRONT AND BACK COPY OF PATIENT’S INSURANCE CARD (S).**

**REFERRING PHYSICIAN INFORMATION**

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did a specialist recommend a referral to our clinic? Yes\_\_\_\_\_ No\_\_\_\_\_

If “Yes”, Please Provide Name/Specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LAB WORK (COMPLETED WITHIN LAST 3 MONTHS- PLEASE ATTACH)**

Date of Last Visit: ­­\_\_\_\_\_\_\_\_\_\_\_\_

Patient Height: \_\_\_\_\_\_\_\_\_\_\_\_Patient Weight: \_\_\_\_\_\_\_\_\_\_\_\_ BMI: \_\_\_\_\_\_\_\_\_\_\_\_BMI%: \_\_\_\_\_\_\_\_\_\_\_\_

Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_\_

Date Labs Were Taken: \_\_\_\_\_\_\_\_\_\_\_\_

Total Cholesterol: \_\_\_\_\_\_\_\_\_\_\_\_HDL: \_\_\_\_\_\_\_\_\_\_\_\_ LDL: \_\_\_\_\_\_\_\_\_\_\_\_ TG: \_\_\_\_\_\_\_\_\_\_\_\_

Hemoglobin A1C: \_\_\_\_\_\_\_\_\_\_\_\_ Fasting Glucose: \_\_\_\_\_\_\_\_\_\_\_\_ AST: \_\_\_\_\_\_\_\_\_\_\_\_ ALT: \_\_\_\_\_\_\_\_\_\_\_

**PLEASE NOTE, LAB WORK MUST BE COMPLETED WITHIN THE LAST 3 MONTHS AND INCLUDED/ ATTACHED. PLEASE ALSO ATTACH PATIENT’S GROWTH CHART WITH HEIGHT, WEIGHT AND BMI LISTED FOR EACH DATE.**

**PLEASE CONTINUE TO PAGE 3**

**ASSOCIATED CO-MORBIDITIES (PLEASE CHECK ALL THAT APPLY)**

* Dyslipidemia
* Hypercholesterolemia
* Hypertension
* Elevated Blood pressure without Hypertension
* Type 2 Diabetes without Complication
* Type 2 Diabetes with Complications
* Hyperinsulinism
* Acanthosis Nigricans
* Metabolic Syndrome
* Polycystic Ovarian Syndrome
* Hypothyroidism
* Obstructive Sleep Apnea
* Hypoventilation Syndrome
* Asthma
* Esophageal Reflux
* Nonalcoholic Fatty Liver Disease
* Elevated Liver Function Tests
* Gallstones
* Musculoskeletal Pain
* Blounts Disease
* Slipped Capital Femoral Epiphysis
* Headaches
* Prader-Willi Syndrome
* Eating Disorder, Anorexia Nervosa; Bulimia Nervosa; Eating Disorder Not Otherwise Specified; \*Binge-Eating Disorder
* Mental Health

Please Indicate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Other Genetic Syndrome

Please Indicate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Other conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*Please note- It is the families’ responsibility to contact**

**ELI clinic at** **918-619-4366 or 918-619-4400 option 2 to schedule an appointment.\*\***