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**PHYSICIAN/PROFESSIONAL REFERRAL FORM to CALIFORNIA CENTER FOR HEALTHY LIVING**

**REFERRING PROVIDER:** \_\_\_\_\_

**REFERRING PROVIDER RELATIONSHIP:**

\_\_\_\_ Primary care physician    \_\_\_\_ Subspecialist    \_\_\_\_ Other \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Referral is generated based on (check all that apply):

\_\_\_\_ physician concern    \_\_\_\_ parent concern    \_\_\_\_ patient concern  
\_\_\_\_ other concern

How long have you known this patient? \_\_\_\_\_

**PLEASE FILL OUT THE FOLLOWING INFORMATION TO THE BEST OF YOUR KNOWLEDGE.**

Past Medical History:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past Surgical History:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Psychiatric/ Social History:

\_\_\_\_\_  
\_\_\_\_\_

Immunizations: \_\_\_\_ up to date    \_\_\_\_ delayed    \_\_\_\_ declined in part or full by family

MOST RECENT HEIGHT: \_\_\_\_\_ (date)

WEIGHT: \_\_\_\_\_ (date)    BMI %ile: \_\_\_\_\_ (date)

DATE OF LAST PHYSICAL EXAM: \_\_\_\_\_

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Abnormalities or concerns from last PE: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How motivated do you feel this child is to make lifestyle changes?

\_\_\_\_ Very motivated    \_\_\_\_ Somewhat motivated    \_\_\_\_ Not very motivated    \_\_\_\_ Not at all motivated

How confident are you that this child will be able to make lifestyle changes?

\_\_\_\_ Very confident    \_\_\_\_ Somewhat confident    \_\_\_\_ Not very confident    \_\_\_\_ Not at all confident

How motivated do you feel this family is to make lifestyle changes?

\_\_\_\_ Very motivated    \_\_\_\_ Somewhat motivated    \_\_\_\_ Not very motivated    \_\_\_\_ Not at all motivated

How confident are you that this family will be able to make lifestyle changes?

\_\_\_\_ Very confident    \_\_\_\_ Somewhat confident    \_\_\_\_ Not very confident    \_\_\_\_ Not at all confident

Please elaborate: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE SEND THE FOLLOWING**, if applicable:

- **GROWTH CHARTS**, including BMI data if calculated, both infant and older child—VERY IMPORTANT! We cannot see the child without this data.
- **CONSULT NOTES** that may have been obtained for a possible obesity-related medical problem (i.e. orthopedic concerns, menstrual irregularities, etc.)
- **LAB WORK** pertinent to complications of obesity, if available, from any time in the past (including normal values). If such lab work has not been drawn, I will obtain indicated blood tests during the intake process.

Thank you very much for your referral! I will be in communication following the assessment to summarize my findings and recommendations for this family.

Elaine Rosen, M.D.

**Please submit all information to:**

California Center for Healthy Living.

16550 Ventura Blvd., Suite 401

Encino, CA 91436

tel: 818.528.5510 • fax: 818.986.1238

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