



# Referral for Consultation Traveling Clinic

for children 2 to 18 years of age

Janeway Lifestyle Program

Please complete and sign then fax/mail to:

## Janeway Lifestyle Program

Room 4J373, 300 Prince Philip Drive, St. John's, NL A1B 3V6

Phone: 777-4387 Fax: 709-777-4736

**Incomplete applications will not be processed.**

### Referring Health Care Professional's Information (please print):

Name: \_\_\_\_\_ Profession: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

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

### Patient Information (please print):

HCN/MCP: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Email: \_\_\_\_\_

Height: \_\_\_\_\_ cm      Weight: \_\_\_\_\_ kg      BMI: \_\_\_\_\_ %

### Reason for Consultation Referral (please check one or more):

- BMI greater than 95<sup>th</sup> percentile     Abnormal lipid profile     Fatty liver     Hypertension
- Signs/symptoms of Insulin resistance (e.g. Impaired Glucose Tolerance, Type 2 Diabetes, PCOS, acanthosis nigricans)

List any other medical conditions (asthma, ADHD, behavioral problems, etc): \_\_\_\_\_

Add any additional information or reports you feel would be helpful to the team at the Janeway Lifestyle Program: \_\_\_\_\_

### Please note:

Lab work is **not** required prior to referral as this will be completed as part of medical workup.

Name: \_\_\_\_\_

Date: \_\_\_\_\_ DD/MONTH/YYYY

Signature: \_\_\_\_\_

**If you are unsure of any part of this referral form or have questions,  
PLEASE CONTACT US!**