

NEPEAN FAMILY METABOLIC HEALTH SERVICE (NFMHS)

KIDS FIT 4 FUTURE CLINIC REFERRAL – AGES 2-15 YEARS

Please note that if you have a patient aged 16 years or above, please refer them to the Adult Healthy Weight Clinic. If you believe that the patient needs an urgent review, then contact the service by telephone directly.

In addition to this referral, please provide:

- ✓ **an up-to-date medication list**
- ✓ **a medical summary**
- ✓ **any other relevant documents**

**THIS IS AN INDEFINITE REFERRAL
(please delete if not applicable)**

A/Prof Gary Leong - if urgent or wish to clarify referral with Dr Leong email service as below

Dear Doctor Leong and KF4F Team,

Thank you for seeing _____ (name), of _____

_____ (address), D.O.B ___/___/____. Their primary contact(s) is/are _____.

Relationship(s) to patient _____. Contact phone number(s) _____.

Date of measure: _____ Weight: _____ kg Height: _____ cm

Calculated BMI: _____ kg/m² Waist Circumference: _____ cm BP: _____ mmHg

Is the patient of Aboriginal/ Torres Strait Islander background? (Please circle)

Does the patient require an interpreter? **YES/NO** (If yes, specify language): _____

Does the patient have a parent/carer who can read and write? **YES / NO**

Parent/Carer(s) at home: Mother Father Other (details : _____)

Mother's name _____ AGE _____ estimated BMI (kg/m²) < 30 30 to < 40 ≥ 40

Father's name _____ AGE _____ estimated BMI (kg/m²) < 30 30 to < 40 ≥ 40

Is the patient and their family *willing and capable* of engaging with an obesity service and do they understand that this will usually involve attending group education sessions? **YES / NO**

(Please note that declining group sessions may delay and/or prevent initiation of treatment).

Is there potential for this patient to have problems attending groups and/or appointments at Nepean Hospital due to certain behaviours (e.g. head banging, shouting, hitting etc.)? **YES / NO**

Have FACS been involved with this patient? **YES / NO** Have FACS requested this referral? **YES / NO / NA**

Have there been any problems in the family related to (tick all that apply):

- Drug Addiction? Domestic Violence? Neglect? Physical abuse? Sexual abuse? Mental Illness?

If you have indicated yes/ticked any of the above, please provide details and/or attach any relevant documents

Name of Doctor: _____ Signature: _____

Practice Address _____

Practice Phone Number: _____ Practice Fax Number: _____ Date: ___/___/___

Nepean Blue Mountains Family Metabolic Health Service, Level 5 South Block, Nepean Hospital

PO Box 63 Penrith, NSW 2751

Ph. (02) 4734 4533 Fax (02) 4734 1920

NBMLHD-FamilyMetabolicHealthService@health.nsw.gov.au

For appointments, please fax or email this referral to the above contacts

Have you referred the patient to Go4Fun® if they are aged 7-13 years? YES / NO

<https://go4fun.com.au/register>

Have you referred the parents to GetHealthy®? YES / NO

<https://www.gethealthynsw.com.au/get-started/>

For more information, please visit the healthykids for professional's website:

<https://pro.healthykids.nsw.gov.au/resources/>

Consider completing online Weight4Kids modules for healthcare providers:

https://weight4kids.learnupon.com/users/sign_in?next=%2Fdashboard

- Please provide supporting evidence for any co-morbidities (e.g. blood tests, liver biopsy reports, sleep study reports, specialist letters), as this will help us to triage your patient so that they can be seen in an acceptable timeframe.
- Attending the FMHS requires a time commitment and patient/ carer motivation to make changes. Patients and their parents/carers need to be well enough to attend multiple appointments, including groups.
- This referral will be assessed by our medical team to determine suitability and you will be notified if the patient cannot be accepted.

Age ≥ 2 and <16 years	<p>BMI > 99.6th Centile by BMI chart (link below) <input type="checkbox"/></p> <p>https://www.rcpch.ac.uk/resources/body-mass-index-bmi-chart RCPCH</p>
	<p>OR BMI >85th centile AND MAJOR obesity-related comorbidity. Please identify the relevant <i>obesity-related co-morbidities or risk factors</i>:</p> <ul style="list-style-type: none"> • Pre-Type 2 diabetes/severe insulin resistance (please circle relevant option) <input type="checkbox"/> • Strong family history of Type 2 diabetes or early-onset ischaemic heart disease (first degree relative at < 50 years of age or ≥ 3 2nd degree relatives < 50 years of age) <input type="checkbox"/> • Hypertension Dyslipidaemia or FHx of Familial Hypercholesterolaemia (FH) (Please circle relevant option) <input type="checkbox"/> • Sleep disordered breathing/OSA -Details: _____ <input type="checkbox"/> • Metabolic Dysfunction Associated Steatotic Liver Disease (MASLD)/MASH <input type="checkbox"/> • Specific end-organ condition directly related to obesity, e.g. Idiopathic intracranial hypertension Details: _____ <input type="checkbox"/> • PCOS with oligomenorrhoea (<9 periods/year)/biochemical hyperandrogenism <input type="checkbox"/> • Orthopaedic e.g SCUFE/Blount Disease Details: _____ <input type="checkbox"/> Pain? Y / N • Behavioural disorder: ASD/ODD/ADHD/other Details: _____ <input type="checkbox"/> _____ • Mental health: Anxiety/ Depression/ Schizophrenia/ Bipolar/ Other <input type="checkbox"/> Details: _____ • Eating disorder (bulimia/ BED/ EDNOS/ other Details: _____ <input type="checkbox"/> • Frequent presentations to hospital in last 12 months with obesity-related condition <input type="checkbox"/> Details: _____ • On waitlist for major surgery (cardiothoracic, abdominal, orthopaedic, neurosurgical) and required to lose weight to reduce operative risk <input type="checkbox"/> • Another family member being seen at the FMHS <input type="checkbox"/> Please provide name(s): _____ <p>Other Details: _____ <input type="checkbox"/></p>