



PowerPlayMD-OC

A **pediatrician** directed health, nutrition and fitness program to manage weight and to **promote healthy, lean and active youth**

Referral Form: Fax to (714) 288 8970

Please include diagnostic impression

Child's Name

1. _____

Child's Age and Date of Birth

2. _____

Name of Parent or Guardian

3. _____

Home address

4. _____

City, Postal Code

Telephone Number

Email address

Health Insurance

Date of Most Recent Visit: _____

Weight: _____ Height: _____ BMI% _____

Latest BP Measure: _____

Medical/psychological problems: _____

Medications: _____

**SCHOOL OR CLINIC
INFORMATION**

Address

Phone number

FAX number

Email address

Name (Please Print)

Title (M.D./R.N./Teacher)

Email address

Signature

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