



# PowerPlayMD-OC

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

## Referral Form

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

\_\_\_\_\_  
Type of 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