HEALTH PARTNERS
In Wellness and Health, Partners for Life.

Healthier You Fit Kids Program Referral	
Referral Information	**Patient Information**
Referring Provider:	Patient Name: DOB:
Preferred Provider Contact: (Phone / Pager / Email)	HP ID#:
Hospital / Clinic Name:	Caregiver's Name:
Today's Date:	Phone:
For questions regarding your referral, please contact the **Nutrition Care Manager** at **(215) 991-4135**	Preferred Language:
	Weight: _____ Height: _____ BMI: _____ BMI %: _____

PRESENTING PROBLEMS (check all that apply):

[ ] **Obesity (Greater than 95% BMI)**
- [ ] With co-morbidities
  - [ ] Diabetes
  - [ ] Hypertension
  - [ ] Sleep Apnea
  - [ ] Hypercholesterolemia
  - [ ] Hypertriglyceridemia
  - [ ] Other (Specify):

_____

- [ ] Without co-morbidities

[ ] **Overweight (Between 85-95% BMI)**

[ ] **Nutritional Concerns (specify):**

_____

[ ] **Disease Management**
- [ ] Asthma
- [ ] Diabetes
- [ ] Other (Specify):

_____

Wellness Interest

[ ] Wellness goals to work on between doctor's visits (Specify):

_____

_____

Please fax completed form to: 267-515-6652,
Attention: Fit Kids Program Referral