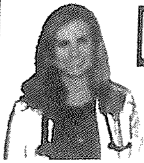

DR.PATRICIA
SERVING KIDS HOPE

Our Vision
Because every child deserves a healthy future.

Child Referral Form

Child Information

Child Name: ______________________

Date of Birth: __________ Age: __ Sex: M/F

Weight: __________ Height: __________

BMI: __________ BP: __________

Date Measured: ______________________

Allergies: ______________________

Medical Hx: ______________________

Pediatrician or PCP Name: ______________________

____

Phone Number: ______________________

Parent Name: ______________________

Phone Number: ______________________

Address: ______________________

____

E-mail: ______________________

Language Spoken: ______________________

Does the child have insurance? Y/N

Name of Health Network:

____

ID Number:

____

Referred By

Please explain the referral to the parents and obtain consent before sending referral

Name: ______________________

Title: ______________________

Address: ______________________

____

Phone: ______________________

Fax: ______________________

E-mail: ______________________

Date Referred: ______________________

Reason for referral: ______________________

____

____

____

____

Any additional information you would like us to know: ______________________

____

____

____

Areas of Concerns

- ☐ Obesity
- ☐ Overweight
- ☐ Underweight
- ☐ Poor nutrition
- ☐ Accelerated weight
- ☐ Decelerated weight (FTT)
- ☐ Family history of obesity
- ☐ Family history of diabetes
- ☐ Poor feeding dynamics
- ☐ Dental Caries
- ☐ Acanthosis nigricans
- ☐ Psychosocial
- ☐ Socioeconomic stressor
- ☐ Elevated HgbA1c
- ☐ Elevated cholesterol
- ☐ Elevated triglycerides

Dr. Riba's Health Club, Inc. asks that this form be used **only** if the child does not have insurance or has PPO insurance. HMO insured children need to be referred by their Primary Care Doctor and Cal-Optima/Medical insured children need to use the correct Cal-Optima/ Medical referral form. Please include all copies of growth chart, release of medical records, insurance card copy, and any labs. Fax completed form to Gabriela Menendez, Case Manager. If you are having trouble with this form or have any other question about how to refer a child please contact us at:
2100 W Alton Ave Suite 2 Santa Ana, CA 92704 Phone: (714) 549-6440 Fax: (714) 549-6449
Also, visit us at www.servingkidshope.org and www.drpatriciamd.com