Texas Center for the Prevention and Treatment of Childhood Obesity

4900 Mueller Blvd. Austin, Texas 78723 | Phone: 512.324.9999 Ext. 86437 | Fax: 512.406.6520 | dellchildrens.net/HealthyLiving

Patient Referral Form

Please Complete, Sign, and Fax Form to ***512.406.6520***

IMPORTANT: Please attach all progress notes, labs within the last six months *(if available)*, and growth chart(s).

Date of Referral: ____ /____ /____

BOX 1: PATIENT DEMOGRAPHIC INFORMATION

Patient Name: ___________________________ Date of Birth: ___ /___ /___ Age:________ Sex: *(Circle One)* M | F
Parent or Guardian Name: ______________________________ Parent or Guardian Phone: ____________________
Patient or Guardian Home Address:______________________ City:_________________ State: ___________ Zip: ________
Family's Preferred Language: English Spanish Other (specify):____

BOX 2: PATIENT INSURANCE INFORMATION

Insurance Name:____ Member Name: _______________________________________
Effective Date: ___ /___ / ___ Group Number:_______________________ ID Number: ______________________________
Eligibility/Benefits/Precertification Phone Number (on back of card):_______________________________________

BOX 3: PROVIDER INFORMATION

Referring Provider:_____________________________________ MD NP PA
Clinic Name *(if applicable)*:____ Provider/Clinic Address: ___________________________
Provider/Clinic Phone: ______________________ Provider/Clinic Fax:_______________________________________

BOX 4: CLINICAL INFORMATION

Date of measurements: ___ /___ /___ Height: ______ in/cm Weight: _____ lbs/kg BMI (kg/m2):_________
BMI Percentile: ______%ile (must be included)
Diagnoses (medical, behavioral, developmental):____
ICD-9 | ICD-10 Code(s):____
List co-morbidities:____

BOX 5: ADDITIONAL INFORMATION

Notes:
____
____
____
____
____

____________________________________ Referring Provider Signature

__________________ Date

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Texas Center for the Prevention and Treatment of Childhood Obesity

Welcome to the Texas Center for the Prevention and Treatment of Childhood Obesity (TCPTCO)! We are excited to start the journey to wellness with you and your patient. Below is a complete list of TCPTCO programs. To assist us in matching your patient with appropriate services, please check **ALL** programs you believe will benefit your patient. Note: program placement is based on specific criteria, availability, and TCPTCO staff assessment of best fit. We may contact you for additional documentation.

CHECK	TCPTCO PROGRAM	CRITERIA	DESCRIPTION
❑	ACES (Activating Children Empowering Success) Clinic*	• Ages 2- 18 years • BMI for age ≥ 95%ile and co-morbidity (e.g. hypercholesterolemia, acanthosis nigricans, elevated blood pressure) • BMI for age ≥ 99%ile	• Individualized family-based intervention • Multidisciplinary team of providers • Nutrition, physical activity, behavioral health • Schedule based on family and clinic availability
❑	Nutrition Consult with Registered Dietitian*	• Ages 0-18 years • BMI for age ≥ 85%ile	• Individual appointment with registered dietitian • Individualized family-based intervention for healthy diet and lifestyle changes
❑	Healthy PIECES (Parenting Intervention for Early Childhood: Education and Skill-Building)*	• Ages 2-6 • BMI for age ≥ 85%ile	• Individual appointments with behavioral health provider • Treatment length – 6 to 12 one-hour sessions
❑	Healthy Living Happy Living++	• Elementary school children (6-12 years) • Parent/guardian required to attend • BMI for age ≥ 85%ile	• 10 week afterschool group program • Nutrition, physical activity, social/emotional health • Wednesdays 4:30- 6:30 PM
❑	TEEN (Teens Empowered for Exercise and Nutrition)	• Ages 13-18 years • Parent/guardian required to attend • BMI for age ≥ 95%ile and co-morbidity • or BMI for age ≥ 99%ile	• 6 or 12 week evening group program • Nutrition, cooking, goal support group, social/emotional health • Tuesdays 5:15-7:30 PM • Individual appointments for social/emotional/family health as needed

*** Note: Visit is billed to insurance ++Please complete physical evaluation on the back for HLHL activity clearance**

How ready is this patient's family to make healthy lifestyle changes? Place an X on the line below.

1 ———————— 5 ———————— 10

Not Ready ***Somewhat Ready*** ***Very Ready***

______________________________ Referring Provider Signature

______________ Date

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Dell Children's Healthy Living Happy Living Physician Evaluation Form

Name: *(Last, First, M.I.)*	***Age***	***M*** ***F***	***DOB*** ____/____/____ ***Date of Exam*** ____/_____/____

PHYSICAL EXAM

General:

Vitals: Wt _________ *Ht* ________ *BMI*________ *BMI %ile*________ *HR*________ *RR*_________ *BP* ________/________

Skin: Normal *Acanthosis Nigricans* *Furunculosis* *Hirsutism* *Excessive Acne*
Irritation/Inflammation *Violaceous striae*

HEENT: Normal *Papilledema* *Tonsillar Size* *EOM*

Neck: Normal *Palpation of Thyroid*

CV: Normal *RRR* *Murmur* *Heave*

Pulm: Normal *Wheezing*

Abd: Normal *Liver Span* *RUQ Tenderness* *Epigastric Tenderness*

GU: Normal *Tanner Stage*

Extremities: Normal

Musculoskeletal: Normal Gait and hip ROM *Abnormal gait* *Bowing of tibia*

Neurologic: Normal *Papilledema*

I hereby provide clearance for participation of this child in Healthy Living Happy Living including the physical activity component (similar exertion to school-based physical education class).

Physician Signature____Date_______________________

Print Name ____Phone Number__________________

Address ____

City_________________________________State_________________________Zip Code____________________________

____ ______________________
Referring Provider Signature Date