Orillia Soldiers' Memorial Hospital
170 Colborne Street West, Orillia ON L3V 2Z3
t 705-325-2201 • **w** www.osmh.on.ca

Choosing Healthy Actions Together (CHAT)
Clinic Referral

Date of referral:

Patient's Name: _____ DOB:_____

Health Card Number:_____

Parent / Guardian Name & Phone Number:_____

Alternate Parent / Guardian Name & Phone Number:_____

Address:_____

❒ **Patient meets criteria for Paediatric Bariatric Clinic (BMI or wt for ht > 85th percentile)**

Comorbidities:

❒ Sleep Apnea ❒ PCOS

❒ Hypertension ❒ Type 2 Diabetes

❒ Hyperlipidemia

Current; Wt: _____ Ht: _____ BMI: _____

List any other medical conditions (asthma, ADHD, behavioral problems, etc):

_____

_____

Current Medications:

_____

_____

_____

Please include copy of WHO Growth Chart ❒ Y ❒ N

Ref Physician Name: _____ Signature:_____

Ref Physician Provider Number:_____ Phone Number: (____)_____

Please fax completed referral to (705) 330 - 3229

FOR OFFICE USE ONLY

Referral Received: _____ **Notified:** _____