Healthy Outcomes Paediatric Program for Scarborough (HOPPS) Referral Form

Patient Information

Date: dd / mm / yy	Last name:		First name:
DOB: dd / mm / yy	Age:	Sex:	Health card number:
Address:			
City:	Province:		Postal code:
Parent/guardian name:	Contact Number:		E-mail address:
Spoken Language:			
Interpreter Required: ☐ Yes ☐ No (Families are encouraged to bring an interpreter; hospital interpreters available)			

Anthropometric Data

Weight (kg):	Height (cm):	BMI:	BP: /

Medical Concerns

☐ GERD	☐ Hypertension	☐ Dyslipidemia	☐ Pre- diabetes
☐ PCOS	☐ Asthma	☐ NAFLD	☐ Type II Diabetes
☐ Sleep apnea	☐ Orthopedic Problems	☐ Microalbuminuria	☐ Acanthosis nigricans
☐ Anxiety	☐ Depression	☐ Autism	☐ ADD/ADHD

Any Other Active Medical Issues/ Medications: _____

Please attach the following and fax the completed referral to 416-284-3168

☐ Growth data (growth charts)

☐ Labs: Fasting glucose, HbA1C, insulin, CBC, ferritin, ALT, ALP, TSH, free T4, ESR, fasting lipid profile and urine analysis

Incomplete referrals will not be processed. *In order to assess suitability for our program, all patients must complete an assessment with our interdisciplinary team. HOPPS does not take responsibility of the patient until assessed and accepted as a patient in our clinic. Due to the length & nature of the program, referrals must be received prior to child's 17th birthday.*

Physician Information

Physician Name (Please Print)	Physician number:	Phone number:	Fax number:
Referral Physician Signature:			Date: