GET UP & GO WEIGHT MANAGEMENT PROVIDER REFERRAL FORM

PLEASE COMPLETE THIS FORM AND FAX TO: 214-456-0194

CHILD'S NAME	PROVIDER NAME AND CLINIC NAME
DATE OF BIRTH	PROVIDER PHONE
CHILD'S STREET ADDRESS	PROVIDER FAX
ADDRESS LINE 2	PARENT EMAIL
CITY/STATE/ZIP	PARENT/GUARDIAN NAME
PARENT/GUARDIAN PHONE NUMBER	RELATIONSHIP TO CHILD
GROUP NUMBER, MEMBER ID	

Select desired program below. (Select both if needed)

☐ **Weight Management** ☐ **Type 2 Diabetes Prevention**

Select this program if child with developmental differences meets enrollment criteria below:

☐ **Weight Management Program for Children with Developmental Differences (CWDD)**

Enrollment Criteria for CWDD:

- Child must have the ability to communicate basic wants/needs verbally
- Child must be comfortable participating in a group setting with peers
- Child must be able to participate in low impact physical activity
- Child must be accompanied by at least one parent or guardian
- Child must be referred by a healthcare provider

Applicable to all Programs

Preferred Language________________

Gender____________________________

Weight (lbs.)_______________________

Height (inches)_____________________

BMI Percentile______________________

Existing Comorbidities_______________

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REFERRAL DISCUSSED WITH PARENT/GUARDIAN?

☐ Yes, referral was discussed and parent/guardian agreed. ☐ No, referral has not yet been discussed with parent/guardian.

REFERRING PROVIDER:

______________________________ ______________________________

PRINT SIGNATURE DATE

ADDITIONAL COMMENTS:

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PROGRAM CONTACT INFORMATION

Weight Management 214-456-6312
Weight Management for CWDD 214-456-2362
Diabetes Prevention Program – 214-456-2362