FIT FAMILIES FAMILIAS En FORMA

I am referring: _____

Student's Name ***Gender*** ***Student's Date of Birth*** ***Age***

_____

Street Address ***Parent/Guardian's Name***

_____

City, State Zip Code ***Parent/Guardian's Daytime Phone***

_____

Student's primary language spoken ***Parent/Guardian's primary language spoken***

for necessary nutrition assessment, medical nutrition therapy, nutrition education, group counseling focusing on behavior modification, and physical activity delivered through the Fit Families program for:

✓	DIAGNOSIS	✓	DIAGNOSIS
	Acquired Acanthosis Nigracans		Hypometabolism
	Abnormal Weight Gain		Family History of Diabetes
	Asthma		Mixed Hyperlipidemia
	Back Pain		Overweight or BMI >85th percentile
	DM Type I, controlled		Rapid Growth
	DM Type I, uncontrolled		Polyphagia
	DM Type II, controlled		Pure Hypercholesterolemia
	DM Type II, uncontrolled		Pure Hypertriglyceridemia
	Eating Disorder, nonspecific		Sleep Apnea
	Elevated Blood Pressure		Tall Stature
	Gynecomastia		Dysmetabolic Syndrome
	Hidden Penis		Hyperlipidemia, unspecified
	Hyperinsulinism		Other Diagnosis:

Relevant lab data and medications: _____

Date taken: _____ Weight: _____ Height:_____ BMI:_____

_____

The Fit Families program, which includes nutrition assessment, medical nutrition therapy, nutrition education, group counseling and physical activity, is a necessary part of the patient's medical treatment for the diagnoses listed above.

_____

*Healthcare Provider's Name Printed *Healthcare Provider's Name Signed

_____

*Street Address *City, State, Zip Code

_____

*Date *Phone Number *Fax Number E-mail Address

*** Information must be provided for us to process this request**

**Parental/Guardian Consent: I understand that my child is being referred to Fit Families. I also understand that the above information may be viewed by, used and released to any and all parties relevant to the healthcare of my child and I give permission to have this information released.

**Consentimiento del Padre o Guardian: Yo entiendo que mi hijo/a esta siendo referido/a a Fit Families. Tambien entiendo que la información en esta forma puede ser examinado por, usada y circulada a todo y cualquier partido que sea relativo al cuidado medico de mi hijo/a y doy permiso de que esta información sea puesta en circulación.

_____ **Parent/Guardian Signature/Firma del Padre o Guardian**

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