Hôpital de Montréal pour enfants
Centre universitaire de santé McGill
Montreal Children's Hospital
McGill University Health Centre

CENTRE OF EXCELLENCE IN ADOLESCENT SEVERE OBESITY (CEASO)

REFERRAL FORM

PLEASE FAX COMPLETED FORM TO 514-412-4319

REFERRAL INFORMATION

Patient Name:____

Patient Phone number:____

Date of Referral (dd/mm/yyyy) ____

Referral Weight (kg) ____

Referral Height (cm) ____

Date of Measure (dd/mm/yyyy) or same as referral date ____________________

Presence of co-morbid conditions (yes/no, specify) _______________________

REFERRING PHYSICIAN

Name and License number____

Contact phone number and address ___________________________________

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Specialty (pediatrician, family doctor, in-hospital) _______________________

SCREENING FOR PATIENT REFERRAL

Is the patient 13 years or older?	YES / NO
Does the patient have either: BMI > 35kg/m^2 with major co-morbidities (i.e., type 2 diabetes mellitus, moderate to severe sleep apnea [apnea-hypopnea index>15], pseudotumor cerebri, or non-alcoholic steatohepatitis (ALT> 35)) OR BMI > 40kg/m^2	YES / NO

Please include copies of all testing recently done in any outside laboratory and growth charts

For questions please contact Carla Farnesi, Clinical Coordinator at 514-412-4400 ext 23346 or carla.farnesi@muhc.mcgill.ca