

Childhood Obesity Referral Form

Cullman, Limestone, Madison, Morgan, Marshall and Jackson Counties

Please fax completed form to 256-382-2175

Recipient Name: _____ Date: _____

DOB: _____ Sex: _____ Recipient/Guardian Phone: _____

Medicaid #: _____ Primary Language: _____

Address: _____

Emergency Contact: _____ Phone: _____

Referring Physician/Facility: _____

Physician Office Contact Name and Number: _____

Date of Visit _____ ****This section to be completed by pediatrician.***

BMI % _____

- BMI < 5% (underweight)
- BMI 5-84% (healthy weight)
- BMI 85-94% (overweight)
- BMI >95% (obese)

Self Management: Goal(s) Selected by Patient/Family

Nutrition:

- Increase fruits/veggies per day (goal 5 per day)
- Decrease or almost none sugar sweetened beverages
- Offer age appropriate portions
- Other: _____

Physical Activity:

- Limit screen time (less than 2 hours per day)
- Increase moderate to vigorous physical activity (1 hour per day)
- Other: _____

Referral to NACC for Childhood Obesity

Patient is between the ages of 3-6 and has a BMI between 85-94%.