**FitKids360 Referral Form** 

**Please fill both front and back out completely**

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| **Referral Information** | |
| **Agency/Provider Name** |  |
| **PCP** |  |
| **Contact Person/Email** |  |
| **Phone #** |  |
| **Fax #** |  |
| **Date Referred** |  |
| **Client Information** | |
| **Caregiver Name** |  |
| **Child’s Name** |  |
| **Child’s DOB** |  |
| **Phone** |  |
| **Address** |  |
| **BMI Percentile** |  |
| **Child’s Insurance** | * **Commercial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** * **Medicaid \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** * **None** |
| **Additional Information** | * **Attach completed FitKids360 Readiness Survey to referral** * **Print off Patient Demographics with insurance information and send with referral** |
| **Please continue to back side of form for additional client information.** | |

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| **Please check medical conditions that apply to patient** |
| * **Asthma (if yes, attach the patient’s asthma action plan)**    + **Inhaler**   + **No Inhaler** |
| * **Diabetes**   + **Type I**   + **Type II** |
| * **Mental Health/Developmental diagnoses (if yes, describe in additional comments section below)** |
| * **Allergies**   + **Food \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   + **Bees** |
| * **Orthopedic/other conditions that may affect child’s participation**   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| * **No medical conditions** |
| **Check one:**   * **Can participate in FitKids360 physical activity with no restrictions.** * **Can participate in FitKids360 physical activity with some restrictions.**   + **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** * **Cannot participate in FitKids360 physical activity.** |
| **Comments:**   * **Need Interpreter \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** * **Need taxi services** * **Additional comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **PLEASE Complete referral and return to**  **Health Net of West Michigan Attn: FitKids360 Team**  **via fax: 616.632.1005**  **Questions? Contact Angelica Pointer at 616-421-9024 or email** [**apointer@healthnetwm.org**](mailto:ntumbarell@healthnetwm.org) |