Success Through Education, Physical Activity and Sharing Information for Kids (S.T.E.P.S.)
Medical Referral Form

Parents, please have your child's doctor complete the following form to participate in the STEPS program and return by fax or email. Padres, por favor haga que el doctor de su niño complete la siguiente forma para poder participar en el programa de STEPS. ***Fax****: 856-575-5184* ***Email****: clarkea@ihn.org If you have questions, please call 856-507-8565. Thank you! İGracias!*

Name of Child: _____

Date of Birth: _____

Parent Name: _____

Parent Phone: _____ Interpreter needed?:_____

BMI: _____

Child must be above the 85th percentile of BMI to participate in the STEPS program.

Is the child's overweight/obesity due to medical causes such as Prader-Willi syndrome, Hypothyroidism, or Polycystic Ovarian Syndrome?
Yes ____ No ____ *If yes, refer to STEPS only if the condition/syndrome is being treated or monitored medically.*

Are medical complications of overweight/obesity present in the child? Yes ____ No ____ *If yes, please select from the list below:*
___ Hypertension ___ Obstructive Sleep Apnea ___ Asthma ___ Hyperlipidemia ___ Severe Joint Pain
___ Other: _____

Blood Pressure/Date: _____

Is child diabetic? Yes _____ No_____

Has parent of child expressed motivation to change lifestyle? Yes ____ No ____

Is it safe for child to participate in moderate to vigorous physical activity? Yes ____ No ____

In order to assess the effectiveness of our program, we would like to follow-up with your office to assess this client's BMI, blood pressure, and risk for diabetes in six and twelve months after the close of the program.

Referring Physician: _____

Signature: _____

Date: _____

Office Contact Information/Stamp: