STEPS for Kids
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****: stepsforkids@ihn.org If you have questions, please call 856-507-8592. Thank you! İGracias!*

Patient Name: _____ Patient age/DOB: _____

Caregiver name/relationship: _____ Caregiver Phone: _____

Caregiver address: _____ City: _____ Zip: _____

Referring Provider: _____ Primary Language: _____

Height: _____ Weight:_ _____ BMI (% and category): _____

Reason for referral: _____

_____

_____

Areas of most concern

❒ Rate of weight gain _____

❒ BMI _____

❒ Family history_____

❒ Diabetes _____

❒ Sleep/OSA _____

❒ Joint problems _____

❒ Psych (depression, anxiety, family stressors, eating disorder) _____

❒ Other _____

Is patient weight 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.*

Please provide

Summary of caregiver motivation _____

What has been done in clinic/office? _____

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

Signature: _____

Date: _____