FKMC MEDICAL REFERRAL & TRACKING FORM *v8.3 August 2015*

Maintain original in medical record, Fax completed 2-Page Form to FKMC - J. Kohlbrenner, 315-361-2043

Child's Name:		DOB:		Gender	Male Female
Caregiver's Name:		Relationship to Patient:			
Address:		Home Phone			
		Cell Phone			
	Parent Email address:				

	Timing >	T1 Referral	T2 Baseline	T3 End FKMC-1	T4 End FKMC-1	T5 Post *[circle]*
	CLINICAL INFORMATION	Pre-FKMC	At FKMC Start	12-Wk Fall	12-Wk Spring	6-M 12-M 24-M
1	Date of Measurement					
2	Weight [kg/#]					
3	Height [Ft & In]					
4	BMI					
5	BMI %tile					
6	Weight Status					
7	Pulse					
8	BP					
9	Time to Bed					
10	Time Awake in AM					
11	Total Hours Sleep					
12	Waist "					
13	Hips"					
14	Waist/Hip Ratio					
15	LABS: ALT		NA	Optional		
16	Glucose		NA	Optional		
17	BUN		NA	Optional		
18	Creatinine		NA	Optional		
19	Lipid- Cholesterol		NA	Optional		
20	Lipid - Triglycerides		NA	Optional		
21	Lipid - HDL		NA	Optional		
22	Lipid - LDL		NA	Optional		
23	Lipid - HDL/LDL Ratio		NA	Optional		
24	HgA1C		NA	Optional		
25	Insulin		NA	Optional		
26	TSH		NA	Optional		
27	Child is free of depression, behavioral issues & risk of self-harm.					
	Signature, Initials & Date					

Referring Physican's Signature verifies: all data & physical ability of child to participate in full, 1 year FKMC Program

Place office label here

Insurance Information		Group ID
Carrier:		
Subscriber:		
Subscriber ID:		

FKMC ...FORM, *continue to p. 2*

FKMC MEDICAL REFERRAL INTAKE FORM, Page 2 of 2

Child's Name:		DOB:		Gender	M F

Are there any other physical, nutritional or behavioral issues or concerns that we should be aware of?

Co-Morbitities [mark all that apply]

28	Type 2 Diabetes					
29	Dyslipidemia					
30	Hyperinsulinemia					
31	Impaired fasting glucose					
32	Non-alcoholic fatty liver disease					
33	Slipped capped femoral epiphysis					
34	Abnormal glucose tolerance					
35	Elevated liver function tests					
36	Blount's disease					
37	Hypertension					
38	Sleep Apnea					
38	Other					

Child/Parent - Permissions, Consents & Release Documentation

1 Release of Confidential Medical Data - HIPAA

I _____ parent of _____ authorize the _____ medical practice

to release the confidential medical information listed above to Oneida Healthcare & Fit Kids of Madison County professional partners, for the purpose of supporting my child, myself and our family in pursuing healthy behaviors over the next school year, including, but not limited to: counseling, social support, nutritional counseling, fitness improvement in support of my child's overweight/obese status. I understand that my child's data will be maintained in a secure, online database, accessible only by designated OHC & Community Partners & that only grouped data will be reported to authorized agencies.

Signed: _____ ***Date:*** _____

2 Consent to Participate in all 3 parts [Nutritional, Fitness & Habits & Behavior] of the FKMC Program

My initials below indicate that I agree and will actively participate & support my child's participation in each and all three parts of the FKMC Program.

NUTRITION		FITNESS		HABITS & BEHAVIOR	
Initials/Date		Initials/Date		Initials/Date	

3 Permission for Photos & Videos

I _____ parent of _____ authorize the ***FKMC Staff***

to photograph and/or videotape my child during the FKMC Program. I also provide permission for photos and/or videotape or myself and members of our family before, during & after the project. Copies will be made for us of all photos/videos.

Signed: _____ ***Date:*** _____

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