KIDSHAPE®

REFERRAL FORM

PLEASE FILL OUT FORM COMPLETELY AND ACCURATELY TO EXPEDITE ENROLLMENT AND THEN FAX OR MAIL TO KIDSHAPE® AT THE ADDRESS LISTED ON THE BOTTOM

I am referring: _____

Student's Name ***Student's Date of Birth***

_____

Street Address ***Parent/Guardian's Name***

_____

City, State Zip Code ***Parent/Guardian's Daytime Phone***

For necessary nutrition assessment, medical nutrition therapy, nutrition education, group counseling focusing on behavior modification, and physical activity delivered through the KidShape® program for:

✓	DIAGNOSIS	ICD-9	✓	DIAGNOSIS	ICD-9
	Acquired Acanthosis Nigracans	701.2		Hypometabolism	783.90
	Abnormal Weight Gain	783.1		Family History of diabetes	V18.0
	Asthma	493.9		Mixed Hyperlipidemia	272.2
	Back Pain	724.6		Obesity, Morbid	278.01
	DM Type I, controlled	250.01		Rapid Growth	v21.0
	DM Type I, uncontrolled	250.03		Polyphagia	783.60
	DM Type II, controlled	250.00		Pure Hypercholesterolemia	272.0
	DM Type II, uncontrolled	250.02		Pure Hypertriglyceridemia	272.1
	Eating Disorder, nonspecific	307.50		Sleep Apnea	780.57
	Elevated Blood Pressure	796.20		Tall Stature	783.9
	Gynecomastia	611.1		Dysmetabolic Syndrome	277.7
	Hidden Penis	752.65		Hyperlipidemia, unspecified	272.4
	Hyperinsulinism	251.1		Other Diagnosis:	

Relevant lab data and medications: _____

Date taken: _____ **Weight:** _____ **Height:** _____ **BMI:** _____

**Parental/Guardian Consent: I understand that my child is being referred to KidShape®. I also understand that the above information may be viewed by, used and released to any and all parties relevant to the healthcare of my child and I give permission to have this information released.

_____ **Parent/Guardian Signature**

The KidShape® program, which includes nutrition assessment, medical nutrition therapy, nutrition education, group counseling and physical activity, is a necessary part of the patient's medical treatment for the diagnoses listed above.

_____

Healthcare Provider's Name Printed ***Healthcare Provider's Name Signed***

_____

Street Address ***City, State, Zip Code***

_____

Date ***Phone Number*** ***Fax Number*** ***E-mail Address***

*** Information must be provided for us to process this request**

Revised: 03-12

KidShape® Foundation • Clinton County Health Department, attn: Kidshape, 133 Margaret Street, Plattsburgh, NY 12901
Phone: 518- 565-4993 or Fax: 518-565-4472