



Weight Center

MassGeneral Hospital
for Children

Tel: 617-726-0373
E-mail: weightcenter@partners.org

Affix Label Here

Pediatric Consult Request

[Please fax to 617-724-2535]

Today's Date: _____

Patient Contact Information

Patient Name: (Last, First, M) _____ **MGH Unit No:** _____
If no number is available, please instruct the patient to call the MGH Registration Center at 866-211-6588.

Patient Date of Birth: _____

Parent/Guardian Name: _____ **Gender:** Male Female

Daytime Phone: _____ **Evening Phone:** _____

Patient Address: _____

City/ State/ Zip: _____ **E-mail Address:** _____

Patient will require an interpreter; Primary Language: _____

Primary Purpose of Referral

Primary purpose of MGH Weight Center Referral (check all that apply):

General obesity medicine consultation Consideration of pharmacological therapy

Consideration of behavioral treatment (e.g. Adolescent group programs or nutritional and physical activity counseling) Consideration of weight loss surgery

Other: _____

Referring Provider

Name of Provider: _____ **Phone:** _____

Practice Name: _____ **Fax:** _____

Are you the patient's PCP? Yes No **If not, PCP Name:** _____

Provider e-mail address:
(For professional communication only) _____

Clinical Information

Weight: _____ **Height:** _____ **BMI (if known):** _____

Major associated disorders (check all that apply):

Social function/ school avoidance Asthma Pseudotumor cerebri

Severe back or joint pain Hypertension Irregular menses or PCOS

Depression or anxiety disorder Sleep apnea Fatty liver disease

Insulin resistance or diabetes mellitus Dyslipidemia Family history of serious obesity-related medical problems

Additional detail on above / other major medical problems: _____

Requested urgency of consultation: (will be reviewed by our Medical Director) Emergent (1-2 weeks) Urgent (1-2 months) Routine (Next Available)

Other issues or considerations: _____

If you have discussed this referral with an MGH Weight Center provider please list provider name: _____

Please fax this form to 617-724-2535