SCHOOL OF MEDICINE
DEPARTMENT OF PEDIATRICS

Healthy & Fit Children's Clinic
Referral Form

ONLY PRIMARY CARE PROVIDERS CAN REFER

REFERRAL DATE: ___________________________

PRIMARY CARE PROVIDER CONTACT INFORMATION:
Primary Care Provider Name: ___________________________
Address: ___________________________
Phone/Fax: ___________________________

TYPE OF SERVICE REQUESTED:
☐ Consult, treatment, and follow-up **(6 visits)**
☐ Can the patient see other UNMH Specialists if needed? ☐ Yes ☐ No

REQUIRED PATIENT INFORMATION:

We need all of the information below filled out completely. This will be sent back to you if not filled out correctly.
PATIENT'S NAME: ___________________________ **DATE OF BIRTH:** ___________________________
Parent's Name: ___________________________ **Day Phone:** ___________________________
Insurance: ___________________________
Spanish Speaking? ☐ Yes ☐ No

Diagnosis: ___________________________

Age: ____________________ **(*Age must be 2-17 years*)**

Weight: ___________kg/lbs **Height:** ___________cm/in **BMI:**___________ **BMI%**___________
Is BMI >85%? ☐ **Yes** ☐ **No** **(*BMI must be >85% to qualify for an evaluation*)**

BLOOD PRESSURE: ***(If available, provide most recent 3 blood pressure measurements)***
BP:__________________ **Date:**_______________
BP:__________________ **Date:**_______________
BP:__________________ **Date:**_______________

Were 5-2-1-0 Lifestyle MESSAGES from *letsgo.org* discussed with the Patient/Family? ☐ Yes ☐ No
LABORATORY DATA: (within the last 6 months) ☐ Yes ☐ No
☐ Fasting lipid panel ☐ Fasting glucose ☐ HgbA1C ☐ AST ☐ ALT ☐ Vit D Screen ☐ Sleep Study
☐ Other

Please send copy of Labs & Growth Chart

Mailing Address:
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1 University of New Mexico
Albuquerque, NM 87131-0001

Healthy & Fit Children's Clinic
Phone (505) 272-5348 Fax (505) 925-4168

Location:
1127 University Blvd NE
Albuquerque, NM 87102-1715