Comanche County
Health Department

Childhood Obesity Referral Form

Date: _____ **Fax:** 580.585.6621

To: Comanche County Health Department **Attn:** Ashley Lazzerini RD LD

From: _____

Name of Client: _____

Sex: *(Circle one)* Male Female **BMI:** _____

DOB:_____ **Age of Client (5-18 Y/O)**_____

Parent/Guardian: **Phone Number:**

Reason for Referral: *(Circle one)*

Obesity Weight Management DMII Prevention

Obesity related Diagnosis Code(s):

_____ _____

_____ _____

Abnormal Nutrition Related Lab Values: (If Available)

NA_____ TC_____ TG_____HDL_____

LDL_____ K+_____Glucose_____HgbA1C_____

Genetic Disposition: *(Circle all that apply)*

DMI DMII High Blood Pressure Cancer Obesity

Heart Disease Renal Disease

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