

## Primary health care assessment (General Practitioner or Practice Nurse).

<b>3-4 year old Immunisation visit</b> Incorporate Connect up 4 Kids Healthy lifestyle information into this visit	<b>Opportunistic consultations</b> 'Every child, every visit'	<b>Kindy Health Screen</b> Letter received by GP → if indicated, recall patient for assessment
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## Basic assessment

- Determine BMI and plot using *CDC BMI-for-age growth charts*.
- The pathway is to be completed by the most appropriate clinician, work within your level of experience and scope of practice.
- **Consider:**
  - Family history (parents, siblings) of obesity and co-morbidities
  - Psychosocial distress
  - Environmental, family and social factors
  - Lifestyle – diet, physical activity, screen time, sleep duration.
  - Growth stage
  - Readiness to change

## Primary prevention

- **Primary health promotion:** Discuss CU4K key messages with family.
- Reinforce any healthy lifestyle behaviours.
- Address any **modifiable risk factors** for childhood obesity identified in assessment:
  - Inadequate sleep (<10 hours/night)
  - Inadequate physical activity (<60mins/day)
  - Excessive screen time (> 2 hours/day)
  - Excessive consumption of foods and beverages from 'extras' food group (>1 serves/day)
  - Parental feeding restriction for weight control
  - Overweight/obese parents or siblings
  - Obesogenic environment
- Work with family to elicit healthy lifestyle strategies where possible (consider local school and sporting programs) and consider providing helpful resources.
- Ensure that parents are aware that they can follow up with GP or practice nurse for further support or any future concerns.

BMI 85<sup>th</sup> - 94.9<sup>th</sup> or <5<sup>th</sup> percentile

If indicated, conduct clinical assessment for underlying cause/co-morbidity (consider history, examinations and investigations)

## Secondary prevention

- **ACT Community Health Intake (CHI) – Womens, Youth Child Nutrition Service** – refer family directly to CHI or
  - Referral form: [health.act.gov.au/health-services/community-based-health-services/](https://www.health.act.gov.au/health-services/community-based-health-services/) (GP's and nurses both use 'GP Only referral form')
  - Fax: 02 6205 2611 or phone: 02 6207 9977
- **Private Paediatric Allied Health Services** - eg. Dietitian, exercise physiologist, psychologist, paediatrician, health coach, community program or private health insurance programs.
- **Private health professionals** in your area with interest in paediatrics refer to the **ACT Child Specific Practitioner List** at <https://www.chnact.org.au/connect-up-4-kids> Monitor progress over 6 months. If unhealthy weight progresses consider referral to level 3 intervention.

BMI >95<sup>th</sup> percentile

Clinical assessment for underlying cause/co-morbidity (consider history, examinations and investigations)

## Tertiary management

- If child is between 4 – 7y .o, arrange referral to **School Kids Intervention Program (SKIP)**.
  - Complete a SKIP referral form [www.health.act.gov.au/SKIP](http://www.health.act.gov.au/SKIP)
  - Email to [SKIP@act.gov.au](mailto:SKIP@act.gov.au) or fax to **6205 1591**.
  - For more information visit [www.health.act.gov.au/SKIP](http://www.health.act.gov.au/SKIP)
- If referral to SKIP is not possible, refer patient to the most appropriate secondary prevention intervention.

**Maintenance.** Progress to this stage once weight management goals achieved. Ongoing monitoring of BMI for at least 6 months to ensure child and family are supported. Refer back into the pathway if progress not sustained.