MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Outpatient Eating Disorders Program Referral Form

Patient Label

REF

PLEASE COMPLETE THIS 4 PAGE FORM IN FULL BEFORE FAXING

Unit Clerk
Eating Disorders Program
Voice Mail: (416) 461-8272 ext: 2426 Fax: (416) 469-6591

Referral Date (DD/MM/YYYY) _____/ _____/_____

Ocean by Cognisant MCI | Ontario eServices Program

We now accept Ocean eReferrals for various clinics. The best way to find Specialist and refer your patients. For more information and to sign-up for your Ocean user account, contact Ontario eHealth

Client Information			
Last Name:	First Name:		Date of Birth: (DD/MM/YYYY)
Preferred Name:		Preferred Pronoun/s:	Age:
Address:		Apt #:	
Town or City:	Province:	Postal Code:	
Health Card Number:	Version:	Expiry Date:	
MRN (if known):			
Gender: ☐ Female ☐ Trans-Woman ☐ Two-Spirit ☐ Gender fluid ☐ Androgynous ☐ Male ☐ Trans-Man ☐ Non-binary ☐ Genderqueer ☐ Other:			
Language(s) Spoken:		Preferred language:	
Interpreter Required: ☐ Yes ☐ No If yes, specify language:		Accessibility Concerns: ☐ Yes ☐ No If yes, specify concern:	
Communication Method: (Please check all that apply)			
Contact Number: Is contact number. a cell phone number ☐ Yes ☐ No		Email Address:	
Consent Signed For: Voice Mail ☐ Email ☐		Has internet access for Video Visits: ☐ Yes ☐ No	
Patient's communication preference for appointment reminder: Voice call ☐ Email ☐ Text ☐			
Emergency Contact Information			
Name:	Phone:	Relationship:	
Is consent provided to contact the above person in case of an emergency? ☐ Yes ☐ No			

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Patient Label

Which ethnicity best describes the client you are referring:	
☐ Black	Eg. African, Afro-Caribbean, African Canadian descent
☐ East/Southeast Asian	Eg. Chinese, Korean, Japanese, Taiwanese descent or Filipino, Vietnamese, Cambodian, Thai, Indonesian, other Southeast Asian
☐ Indigenous (First Nations, Métis, Inuk/Inuit)	Eg. First Nations, Métis, Inuk/Inuit descent
☐ Latino	Eg. Latin American, Hispanic descent
☐ Middle Eastern	Eg. Arab, Persian, West Asian descent (Afghan, Egyptian, Iranian, Lebanese, Turkish, Kurdish)
☐ South Asian	Eg. South Asian descent (East Indian, Pakistani, Bangladeshi, Sri Lankan, Indo-Caribbean)
☐ White	Eg. European descent
☐ Another race category	Includes values not described above
☐ Do not know	Not applicable
☐ Prefer not to answer	Not applicable

Referring Provider Information				
Is referral being made by patient's primary care provider? ☐ Yes ☐ No		If no: Primary care provider name: Primary care provider telephone:		
Last Name:		First Name:		
Referral Source:		Title/ Position:		
Address:		City:	Province:	Postal Code:
Date of Referral (MM/DD/YYYY):	Phone:	Fax:	Physician Billing Number:	

Your patient should continue under your care for their Eating Disorder concerns until their assessment takes place. If a crisis situation arises please inform them to go to their closest Emergency Department.

Physician CPSO # _____ **Signature:** _____

Preferred Services: ☐ Outpatient Program ☐ At-home Program
Is the patient/family aware of and in agreement with the referral? ☐ Yes ☐ No

Reason for referral
☐ Anorexia Nervosa ☐ Bulimia Nervosa ☐ Binge Eating Disorder ☐ ARFID (Avoidant Restrictive Food Intake Disorder) ☐ OSFED (Other Specified Feeding or Eating Disorder) Other:
Prior Medical Diagnoses
Other medical diagnoses:

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Patient Label

Prior Treatment For This Condition and/or Other Conditions

☐ Previous history of hospitalization for an Eating Disorder ☐ No ☐ Yes (*If yes, when & where*)

☐ Previous Outpatient Treatment for an Eating Disorder ☐ No ☐ Yes *(If yes, when & where)*

Name of healthcare provider and tel. #

Prior Psychiatric Diagnoses and/or Treatment: (Please include all psychiatric reports if applicable)

☐ Self-Harm Behaviours

☐ Suicidal Ideation or Intent ☐ History of CAS involvement

☐ Other:

Weight & Height: (Please provide a growth chart or complete growth history in addition to below)

Please record **Current Weight** **Date taken:** Kg or lb.		Please record **Current Height** **Date taken:** cm or ft/in	
Weight Loss	**Onset**	**Duration**	**Precipitating Factors**
Yes ☐ No ☐ **kg**			

Eating Disorder Symptoms (to select all applicable): ☐ Restricting ☐ Exercise ☐ Binge Episodes ☐ Intentional Vomiting ☐ Misuse of Laxatives ☐ Diuretics ☐ Diet pills ☐ Complementary and alternative medicines ☐ Other:

Menses: *(if applicable)*	Menarche:
	Typical cycle:
	Last Menstrual Period:
	Last Normal Menstrual Period:
	1º amenorrhea:
	2º amenorrhea / length:
	Weight when menses were lost:

Medications:

Prescribed: Name(s) & dose(s) & frequency

Non-prescription: Name(s) & dose(s) & frequency

ECG & Lab Work: (Please have all of the following completed and faxed to us at time of referral- should be performed within 2 weeks of referral*)*

☐ Sodium ☐ Potassium ☐ Chloride ☐ Glucose ☐ Urea ☐ Calcium ☐Phosphate ☐Magnesium ☐ALT ☐Amylase ☐Total Protein ☐Albumin ☐Creatinine ☐TSH ☐ AST ☐CBC, Diff., Platelets ☐ESR ☐Electrocardiogram

In assigned female patients: LH, FSH, estradiol

In assigned male patients: testosterone

To consider including if clinically indicated: prolactin, pregnancy test, vitamin B12, iron studies

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Medical Stability: (Please fill out completely with current information)			
Blood Pressure	**Supine:**	**Standing:**	**Date taken:**
Heart Rate	**Supine:**	**Standing:**	**Date taken**:
Temperature (in Celcius)			**Date taken:**

Please indicate if the patient has been assessed/ seen, or is being followed, in any other eating disorder program at current time.

Please indicate if the patient has been referred to any other eating disorder programs at current time.

For office use only:

Appointment Offered (DD/MM/YYYY):_____ Clinic Assigned:_____

Clinician assigned:_____

Appointment confirmed by: _____

Completed by (Name &Title): _____

Date (DD/MM/YYYY): _____