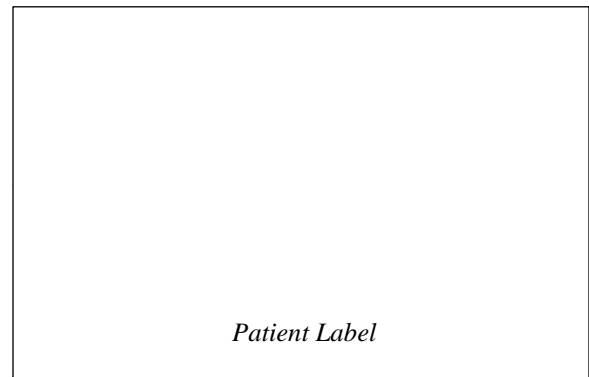


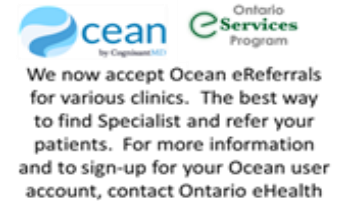
Outpatient Eating Disorders Program Referral Form



Patient Label

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) ____/____/____

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: <input type="checkbox"/> Female <input type="checkbox"/> Trans-Woman <input type="checkbox"/> Two-Spirit <input type="checkbox"/> Gender fluid <input type="checkbox"/> Androgynous <input type="checkbox"/> Male <input type="checkbox"/> Trans-Man <input type="checkbox"/> Non-binary <input type="checkbox"/> Genderqueer <input type="checkbox"/> Other:				
Language(s) Spoken:		Preferred language:		
Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify language:		Accessibility Concerns: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify concern:		
Communication Method: (Please check all that apply)				
Contact Number: Is contact number a cell phone number <input type="checkbox"/> Yes <input type="checkbox"/> No		Email Address:		
Consent Signed For: Voice Mail <input type="checkbox"/> Email <input type="checkbox"/>		Has internet access for Video Visits: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Patient's communication preference for appointment reminder: Voice call <input type="checkbox"/> Email <input type="checkbox"/> Text <input type="checkbox"/>				
Emergency Contact Information				
Name:		Phone:	Relationship:	
Is consent provided to contact the above person in case of an emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No				

<i>Patient Label</i>

Which ethnicity best describes the client you are referring:

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

Referring Provider Information

Is referral being made by patient's primary care provider? <input type="checkbox"/> Yes <input type="checkbox"/> 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

<input type="checkbox"/> Anorexia Nervosa	<input type="checkbox"/> Bulimia Nervosa	<input type="checkbox"/> Binge Eating Disorder
<input type="checkbox"/> ARFID (Avoidant Restrictive Food Intake Disorder)	<input type="checkbox"/> OSFED (Other Specified Feeding or Eating Disorder)	
Other:		

Prior Medical Diagnoses

Other medical diagnoses:

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:		Please record Current Height Date taken:	
Kg or	lb.	cm or	ft/in
Weight Loss	Onset	Duration	Precipitating Factors
Yes <input type="checkbox"/> No <input type="checkbox"/> 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:
	1° amenorrhea:
	2° 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

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): _____