Child & Adolescent Mental Health Care Program
Eating Disorders Referral Form

Today's Date: ______________________________ Health Card # ___________________________________

Patient's Name: ____ DOB: _______/_______/_______
Day Month Year

Address: ____ Postal Code: ____________________

Parent/Guardian Names: ____

Phone #(Res) ________________________ (Bus)________________________(Cell)___________________

Email Address: ____

Who does patient reside with? ☐ Both parents ☐ Mother ☐ Father ☐ Guardians

Who has custody of patient: ☐ Joint ☐ Mother ☐ Father ☐ Guardians ☐ Ward of CAS

Step-Parent(s) Name: ____

Phone #(Res) ________________________ (Bus)_________________________ (Cell)_________________

Referring Physician: ____ (Specialty)________________

Address: ____

Phone #____ FAX #______________________________

Email Address ______________________________________ Physician Referring #______________________

Family Doctor/Paediatrician: ____

Please note: Please print or type all information ***legibly***. Please complete all sections. Your referral will not be processed until all information is received.

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COMMENTS: ____

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Clinical Urgency Please circle one Crisis Urgent Semi-Urgent Elective

Please return entire form by fax to: **Child & Adolescent Mental Health Care Program**
Eating Disorders
Attention: Intake Office

Phone: (519) 667-6640 **Fax: (519) 667-6814**

PRESENTING PROBLEM(S): **DIAGNOSIS:**

PRESENTING PROBLEM(S)	DIAGNOSIS
1. 2. 3.	

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 Lbs.	Cm Ft/In
Previous Weights: Lowest kg/lbs Date of lowest wt:	Previous Weights: Highest kg/lbs Date of highest wt:

Weight Loss	Onset	Precipitating Factors	Duration

WEIGHT CONTROL METHODS	No	Yes	FREQUENCY Per Day	Per Week
Food Restriction				
Binge				
Vomiting				
Laxatives				
Diuretics				
Ipecac				
Diet Pills				
Exercise				

MENSES: Menarche: ____

Usual Cycle: ____

Last Menstrual Period: ____

Last Normal Menstrual Period: ____

1° amenorrhea: ____

2° amenorrhea / length: ____

LAB WORK: Please have the following lab work completed and faxed to us at time of referral

	Sodium		Potassium		Chloride
	Glucose		Urea		Calcium
	Phosphate		ALT		Total Protein
	AST		CBC, Diff., Platelets		ESR

Electrocardiogram (ECG) completed date: ____

MEDICAL STABILITY: **VERY IMPORTANT…PLEASE FILL OUT COMPLETELY WITH CURRENT INFORMATION**

Blood Pressure	lying	standing	Date taken
Heart Rate	lying	standing	Date taken
Oral Temperature	F C		Date taken
Hydration	poor fair good very good		Date taken

MEDICATIONS:

Prescribed: Name(s) & dose(s)
Non-prescribed: Name(s) & dose(s)

PRIOR MEDICAL DIAGNOSES AND/OR TREATMENT FOR THIS CONDITION AND/OR OTHER CONDITIONS

Previous Treatment for an Eating Disorder: ☐ Yes ☐ No

If yes, when & where ____

____

Name of healthcare provider and tel. #: ____

Other medical diagnoses: ____

PRIOR PSYCHIATRIC DIAGNOSES AND/OR TREATMENT:

☐ Suicidal behaviour
☐ Suicidal ideation
☐ OCD
☐ Depression
☐ Anxiety Disorder

☐ Self Harm Behaviours ________________________________
☐ History of CAS involvement
☐ History of Abuse ☐ Sexual ☐ Physical ☐ Emotional
☐ History of Legal Trouble (police involvement)
☐ Substance Abuse ☐ ETOH ☐ Other ___________________

Please provide a *separate* formal referral note.