Children's Hospital
London Health Sciences Centre

Child & Adolescent Mental Health Program – Eating Disorders Referral Form

800 Commissioners Rd. E.
Zone B, 8th Floor, P.O. Box 5010
London, Ontario N6A 5W9
Phone: 519-667-6640
Email: camhintake@lhsc.on.ca

- Please fax all referrals to Centralized Intake: 519-667-6814
- Please direct any inquiries to 519-667-6640
- Please complete the referral form in full, and include a growth chart and vitals
- Please ensure bloodwork and ECG are attached to the referral

The Child and Adolescent Mental Health Care Eating Disorders Program provides clinical services for children and youth up to 17 years of age and their families residing in the London-Middlesex, Oxford, Elgin, Huron, Perth, Lambton, Grey, Bruce, Chatham-Kent, and Windsor-Essex areas. **Referrals to the Eating Disorder Program must be made by a physician who accepts responsibility for medical care until patients are seen for assessment.**

The Child and Adolescent Mental Health Care Program accepts referrals for the following difficulties:

- Patients experiencing moderate-severe eating disorder symptoms: a) significant and/or rapid weight loss AND/OR (b) frequent and persistent unhealthy eating related behaviours.
- ARFID: experiencing at least ONE of the following: growth failure, nutritional deficiency directly related to nutritional intake or full dependence on nutritional supplements.

Exclusionary Criteria:

- Patients over the age of 17.5 years old at time of referral
- Children under 7 years of age
- Weaning from G Tubes is not in our scope of practice
- Longstanding stable selective eating

PATIENT INFORMATION

Patient's Name: _____ DOB (dd/mm/yy) _____ Age: _____
Address: _____
City: _____ Postal Code: _____
Health Card Number (including version code): _____
Phone Number: _____ Cell Phone Number: _____
Is the patient agreeable to this referral: Yes ( ) No ( )

PARENT/GUARDIAN INFORMATION

Use Box 2 to provide information of second parent when residence differs and there is joint/shared custody

Box 1	Box 2
Name(s): _____	Name: _____
Relationship to Child: _____	Relationship to Child: _____
Address: _____	Address: _____
City: _____ Postal Code: _____	City: _____ Postal Code: _____
Phone: _____	Phone: _____

REFERRING PHYSICIAN/NP (mandatory for accessing service)

Name of Referring Physician (please print): _____ Billing Number: _____
Phone Number: _____ Fax Number: _____
Physician Address: _____
Family Physician (if different from referring physician): _____
Signature of Referring Physician: _____ Date of Referral: _____

PRESENTING PROBLEMS:

1.
2.
3.

Onset:

Precipitating Factors:

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VERY IMPORTANT: WEIGHT & HEIGHT: PLEASE PROVIDE A GROWTH CHART & COMPLETE GROWTH HISTORY IN ADDITION TO BELOW

Highest Weight: Date Taken:	Lowest Weight: Date Taken:	Current Weight: Date Taken:	Current Height: Date Taken:
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	C / F		Date Taken:
Hydration	( )Poor( ) Fair ( )Good( )Very Good		

MEDICATIONS: Please include both prescribed and non-prescribed medications

Prescribed		**Non-Prescribed**	
Name	**Dosage**	**Name**	**Dosage**

Weight Control Methods			**Frequency**		
			Per Day	**Per Month**	**Details (Duration of symptoms)**
Food Restriction	☐ No	☐ Yes			
Binge	☐ No	☐ Yes			
Vomiting	☐ No	☐ Yes			
Laxatives	☐ No	☐ Yes			
Diuretics	☐ No	☐ Yes			
Diet Pills	☐ No	☐ Yes			
Exercise	☐ No	☐ Yes			

Menses:
Last Menarche:
Usual Cycle:
Last Menstrual Period:

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

Sodium	**Potassium**	**Chloride**	**Albumin**	**Random Glucose**
Urea	**Calcium**	**ALP**	**Phosphate**	**ALT**
Electrolytes	**Total Bilirubin**	**AST**	**CBC**	**Creatinine**
Magnesium	**Magnesium**	**Amylase**	**TSH**	**Phosphate**

Electrocardiogram (ECG) date: _____ ****Please attach ECG to referral package****

ACCESS TO EATING DISORDER AND/OR MENTAL HEALTH SUPPORTS & SERVICES

Past eating disorder and/or mental health treatment/diagnosis/admission: Yes ( ) No ( )
If yes, please specify when and where: _____
_____
Current eating disorder and/or mental health supports and/or services: Yes ( ) No ( )
If yes, please specify: _____
_____

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Please check off the following that apply to your patient's history and current presentation

Concern	Current	Past	Details	Concern	Current	Past	Details
Self-Harm				Suicidal Ideation			
Suicide Attempt(s)				Substance Use			
Trauma				Anxiety			
Depression				Obsessions/ Compulsions			
Hallucinations				Delusions			
Hyperactivity				Developmental Delay			
Violence/Acts of Aggression				Oppositional Behaviour			

Comments: