Child & Adolescent Mental Health Care Program
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Children's Hospital
London Health Sciences Centre

CHILD & ADOLESCENT MENTAL HEALTH CARE PROGRAM
EATING DISORDERS REFERRAL FORM

Name of child or adolescent:______________________________ Sex: M F

Date of Birth: ______/______/______ Age: ______ Health Card Number: ______________________

Year Month Day

Name of parent/guardian: ______________________________

Phone number(s)-Home: ______________Work: ______________Cell______________

Address: ______________________________

____

Who does patient reside with? ☐ Both parents ☐ Mother ☐ Father ☐ Guardian(s)

Custody Status: ☐ Joint ☐ Mother ☐ Father ☐ Guardians ☐ Ward of CAS

Referring Physician: ______________________(Specialty) ______________

Address: ______________________________

Phone # ______________ FAX # ______________

PRESENTING PROBLEM(S):

1. ______________________________
2. ______________________________
3. ______________________________

Onset:______________________________

Precipitating factors:______________________________

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:

WEIGHT CONTROL METHODS **FREQUENCY**

			PER DAY	PER MONTH
Food Restriction	☐ **No**	☐ **yes**		
Binge	☐ **No**	☐ **yes**		
Vomiting	☐ **No**	☐ **yes**		
Laxatives	☐ **No**	☐ **yes**		
Diuretics	☐ **No**	☐ **yes**		
Diet Pills	☐ **No**	☐ **yes**		
Exercise	☐ **No**	☐ **yes**		

MENSES: 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	Phosphate	Amylase	TSH

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	C/F		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
☐ Substance Abuse ☐ ETOH ☐ Other __________________
☐ Self Harm Behaviours ______________________________
☐ History of CAS involvement
☐ History of Abuse ☐ Sexual ☐ Physical ☐ Emotional
☐ Anxiety Disorder

COMMENTS______________________________

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