



596 Davis Drive
Newmarket, ON L3Y 2P9

Child & Adolescent Mental Health
FAX: 905-830-5979

Health Record #: _____ Complete or place barcoded patient label here
 Patient Name: *(Print first, last)* _____
 DOB: dd / mm / yy Age: _____ Female Male
 OHIP #: _____ Version Code: _____
 Account #: _____ Date of Admission: dd / mm / yy

Young Adult Eating Disorders Program Referral *(Patients between 17.5 and 24.5 years of age)*

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: <u>dd</u> / <u>mm</u> / <u>yy</u> _____ kg or _____ lb.	Please record Current Height Date taken: <u>dd</u> / <u>mm</u> / <u>yy</u> _____ cm or _____ ft/in
Lowest Previous Weight: Date of lowest wt: <u>dd</u> / <u>mm</u> / <u>yy</u> _____ kg or _____ lb.	Highest Previous Weight: Date of highest wt: <u>dd</u> / <u>mm</u> / <u>yy</u> _____ kg or _____ lb.

Weight Loss	Onset	Duration	Precipitating Factors
<input type="checkbox"/> No <input type="checkbox"/> Yes _____ kg	<u>dd</u> / <u>mm</u> / <u>yy</u>		

WEIGHT CONTROL METHODS	No	Yes	WEIGHT CONTROL METHODS	No	Yes
Food Restriction			Ipecac		
Binge			Diet Pills		
Vomiting			Exercise		
Laxatives			Other		
Diuretics					

MENSES: <i>(if applicable)</i>	Menarche:
	Usual Cycle:
	Last Menstrual Period:
	Last Normal Menstrual Period:
	1° amenorrhea:
	2° amenorrhea / length:

MEDICATIONS:

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

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



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DOB: <u>dd</u> / <u>mm</u> / <u>yy</u>	Age: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male
OHIP #: _____	Version Code: _____
Account #: _____	Date of Admission: <u>dd</u> / <u>mm</u> / <u>yy</u>

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ECG & LAB WORK: <i>Please have all of the following completed and faxed to us at time of referral</i>								
Sodium	Potassium	Chloride	Glucose	Urea	Calcium	Phosphate	ALT	Amylase
Total Protein	Albumin	Creatinine	TSH	AST	CBC, Diff., Platelets	ESR	Electrocardiogram	

MEDICAL STABILITY: ** VERY IMPORTANT...PLEASE FILL OUT COMPLETELY WITH CURRENT INFORMATION**			
Blood Pressure	supine	standing	Date taken: <u>dd</u> / <u>mm</u> / <u>yy</u>
Heart Rate	supine	standing	Date taken: <u>dd</u> / <u>mm</u> / <u>yy</u>

PRIOR MEDICAL DIAGNOSES AND/OR TREATMENT FOR THIS CONDITION AND/OR OTHER CONDITIONS	
Previous history of hospitalization for an Eating Disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>(If yes, when & where)</i> _____
Previous out-patient treatment for an Eating Disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>(If yes, when & where)</i> _____
Name of Healthcare Provider and tel. #: _____	
Other medical diagnoses: _____	

PRIOR PSYCHIATRIC DIAGNOSES AND/OR TREATMENT:			
<input type="checkbox"/> Suicidal behaviour	<input type="checkbox"/> Self Harm Behaviours _____		
<input type="checkbox"/> Suicidal Ideation or Intent	<input type="checkbox"/> History of CAS involvement	<input type="checkbox"/> OCD	
<input type="checkbox"/> Borderline Personality Disorder	<input type="checkbox"/> Depression	<input type="checkbox"/> History of Abuse	<input type="checkbox"/> Sexual <input type="checkbox"/> Physical <input type="checkbox"/> Emotional
<input type="checkbox"/> Residential Treatment	<input type="checkbox"/> History of Legal trouble <i>(police involvement)</i>		
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> ETOH	<input type="checkbox"/> Other _____

Please return all forms to: Eating Disorder Program
Southlake Regional Health Centre
596 Davis Drive, Newmarket L3Y 2P9

Attention: Intake Worker
Phone: (905) 895-4521 ext. 2825
Fax: (905) 830-5979

COMPLETION CHECKLIST: Have you completed all 3 pages of this referral form? Attached or faxed all lab results? Attached or faxed all ECG

PLEASE NOTE: Please complete all sections. Your patient cannot be assessed at the Eating Disorder Program at Southlake Regional Health Centre until **all** this information has been received by us. Please use the *Completion Checklist* above to ensure you have included everything necessary for us to proceed with scheduling an assessment appointment for your client.

BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL					
Referring Physician: <i>(print first, last)</i> _____			Billing #: _____		
Signature: _____			Date: <u>dd</u> / <u>mm</u> / <u>yy</u>		
Address: Street Number and Name _____		Apartment _____	City _____	Province _____	Postal Code _____
Telephone Number: _____			Fax Number: _____		
Are you? <input type="checkbox"/> Family Physician <input type="checkbox"/> Other <i>(specify)</i> _____					