SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Child & Adolescent Mental Health
Eating Disorders Program

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

Physician Referral

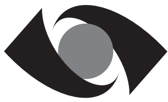
Please print legibly

Patient's Name: *(print first, last)*			**Date of Birth:** mm / dd / yy	
Address: Street Number and Name	Apartment	City	Province	Postal Code
Home Phone Number:	❑ can call this number	❑ can leave messages	❑ on voicemail	❑ with person
Cell Phone Number:	❑ can call this number	❑ can leave messages	❑ on voicemail	❑ with person
Sex: ❑ Male ❑ Female	**Health Card #:**		**Version Code:**	
Parent/Guardian Names: *(print first, last)*				
Home Phone Number:	❑ can call this number	❑ can leave messages	❑ on voicemail	❑ with person
Cell Phone Number:	❑ can call this number	❑ can leave messages	❑ on voicemail	❑ with person
Guarantor: *(if patient 15 years of age or younger)*				
Guarantor Health Card #: *(this is optional)*	**Version Code:**		**Phone Number:**	
Name of Emergency Contact: *(print first, last)*				
Relationship to Patient:			**Phone Number:**	
Who does patient reside with? ❑ Both Parents	❑ Mother	❑ Father	❑ Guardians	
Who has custody of patient: ❑ Joint	❑ Mother	❑ Father	❑ Guardians	❑ Ward of CAS
Are parents aware of the referral being made?	❑ YES	❑ NO		
Name of Family Physician: *(print first, last)*			**Phone Number:**	
Reason for Referral:				

Has this patient been referred to any other treatment facility/person for her/his eating disorder at the same time that they are being referred to Southlake Regional Health Centre? ❑ NO ❑ YES *(If **YES**, where are they being referred?)*

____

SL0325_11 (01/14) "Child & Adolescent Mental Health" Review (01/17)



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Account #: ______________________   Date of Admission: mm / dd / yy

Physician Referral

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

WEIGHT & HEIGHT: Please provide a growth chart or complete growth history in addition to below

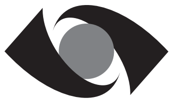
Please record **Current Weight**	Please record **Current Height**
Date taken: mm / dd / yy ____________ kg or ____________ lb.	**Date taken:** mm / dd / yy ____________ cm or ____________ ft/in
Lowest Previous Weight: **Date of lowest wt:** mm / dd / yy ____________ kg or ____________ lb.	**Highest**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

Weight Loss	Onset	Duration	Precipitating Factors
❑ No ❑ Yes ______ **kg**	mm / dd / yy		

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

MENSES: *(if applicable)*	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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OHIP #: ______ Version Code: ______
Account #: ______ Date of Admission: mm / dd / yy

Physician Referral

ECG & LAB WORK: *Please have all of the following completed and faxed to us at time of referral*

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:** mm / dd / yy
Heart Rate	**supine**	**standing**	**Date taken:** mm / dd / yy
Oral Temperature	**F** **C**		**Date taken:** mm / dd / yy
Hydration	**poor fair good very good**		**Date taken:** mm / dd / yy

PRIOR MEDICAL DIAGNOSES AND/OR 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. #: ______
❑ **Other medical diagnoses:** ______

PRIOR PSYCHIATRIC DIAGNOSES AND/OR TREATMENT:

❑ Suicidal behaviour
❑ Self Harm Behaviours ______
❑ Suicidal Ideation or Intent
❑ History of CAS involvement
❑ OCD
❑ Borderline Personality Disorder
❑ Depression
❑ History of Abuse ❑ Sexual ❑ Physical ❑ Emotional
❑ Residential Treatment
❑ History of Legal trouble *(police involvement)*
❑ Anxiety Disorder
❑ Substance Abuse ❑ ETOH
❑ Other ______

Please return all forms to:

Eating Disorder Program
Southlake Regional Health Centre
Phone: (905) 895-4521 ext. 2825

Attention: Regional Intake Worker
596 Davis Drive, Newmarket L3Y 2P9
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 results?

Please Note: Please complete all sections. Your patient can not 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.

Referring Physician Name: *(print first, last)*
Referring Physician Billing #:
Referring Physician Signature:
Date: mm / dd / yy
Address: Street Number and Name Apartment City Province Postal Code
Telephone Number:
Fax Number:
Are you? ❑ Family Physician ❑ Paediatrician ❑ Other *(specify)* ______

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