

Adult Eating Disorders Referral For Assessment (Part I)

Telephone: (709) 777-2041 Fax referral to:(709) 777-2042



Name: _____

HCN: _____

Date of Birth: _____

INFORMATION FOR REFERRAL SOURCES:

1. Part I and Part II are Required to be completed **in full**. Incomplete forms will not be processed.
2. This form is used for screening purposes. People will be contacted directly for an assessment appointment which will determine appropriate level of care. (Outpatient, HOPE Program or Inpatient Treatment)
3. The Family Physician or Nurse Practitioner is responsible for the medical monitoring of their patient while waiting for inpatient admission and post-discharge. The Family Physician or Nurse Practitioner is required to medically monitor their patient while participating in the Outpatient or HOPE Program. Please refer to assessment guidelines for hospitalization of patients with Eating Disorders.
4. A person must be 15 years of age or older to participate in the HOPE Program.
5. Primarily, people over 18 years of age will be admitted to the inpatient treatment program at the Health Science Center.
6. The use of this form is for consultation and treatment for **Anorexia Nervosa, Bulimia Nervosa, and Other Specified Feeding and Eating Disorder (OSFEDS)**.

SECTION I (To be completed by Referral Source)

REFERRAL DATE: DD/MONTH/YYYY

PATIENT INFORMATION			
Allergies: _____			<input type="checkbox"/> No Known
Telephone: _____		Can a message be left? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Street Address _____	City _____	Province _____	Postal Code _____
REFERRAL SOURCE		<i>Affix Rubber Stamp if applicable</i>	
Name: _____			
Telephone: _____ Fax: _____			
Address: _____			

MENTAL HEALTH HISTORY			
Reason(s) for referral:			
1. _____			
2. _____			
3. _____			
Additional Mental Health and Addictions History (<i>Please include other psychiatric illnesses, substance use, history of suicidal/homicidal ideation, and any other relevant information</i>):			
Is the client able to participate in a group-based program? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Name: _____

Date: DD/MONTH/YYYY

Signature: _____

Adult Eating Disorders Referral For Assessment (Part II)

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Name: _____

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SECTION II (To be completed by Physician/Nurse Practitioner)

EATING DISORDER SYMPTOMS					CURRENT MEDICATIONS			
			FREQUENCY			NAME	DOSE	FREQUENCY
	YES	NO	PER DAY	PER WEEK				
Food Restriction					1			
Binge Eating					2			
Induced Vomiting					3			
Laxatives					4			
Diet Pills					5			
Diuretics					6			
					7			

Exercise History

PHYSICAL EXAMINATION

BMI		Temperature	
Current Height		Last Menstrual Period	
Current Weight		Blood Pressure (Lying x 5 minutes)	
Weight Loss		Blood Pressure (Standing x 2 minutes)	
Maximum Weight		Pulse (Lying x 5 minutes)	
Minimum Weight		Pulse (Standing x 2 minutes)	

Please complete and attach ECG and Blood Work: CBC, Lytes, BUN, Creatinine, Glucose, Calcium, Magnesium, Inorganic Phosphorus, Ferritin, B12

Systemic Examination

Authorizing Prescriber's Name: _____ Date: DD/MONTH/YYYY _____

Authorizing Prescriber's Signature: _____