Eastern Health
Mental Health and Addictions Program

Adult Eating Disorders Referral For Assessment (Part I)

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

Incomplete forms will not be processed

AS5770 1891 05 2018

Name:

HCN:

Date of Birth:

INFORMATION FOR REFERRAL SOURCES:

1. Part I and Part II are Required to be completed **in full**.
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 18 years of age or older to participate in the HOPE Program.
5. The use of this form is for consultation and treatment for **Anorexia Nervosa, Bulimia Nervosa, and Other Specified Feeding and Eating Disorder (OSFEDS)**.
6. Referrals for **Binge Eating Disorder (BED) or Avoidant Restrictive Food Intake Disorder (ARFID)** will not be accepted**.**

SECTION I (To be completed by Referral Source)

Referral Date: _____DD/MONTH/YYYY_____

PATIENT INFORMATION

Allergies: ☐ No Known

Telephone: | Can a message be left? ☐ Yes ☐ No

Street Address | City | Province | Postal Code

REFERRAL SOURCE

Name: _____

Telephone:_____ Fax:_____

Address:_____

_____

Affix Rubber Stamp if applicable

MENTAL HEALTH HISTORY

Reason(s) for referral:

1. _____
2. _____
3. _____

Additional Mental Health and Addictions History *(Please include other psychiatric illnesses, substance use, history of suicidal/homicidal ideation, and any other relevant information):*

Is the client able to participate in a group-based program? ☐ Yes ☐ No

Name:_____ Date:_____DD/MONTH/YYYY_____

Signature:_____

Eastern Health
Mental Health and Addictions Program

Adult Eating Disorders Referral For Assessment (Part II)

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

AS5770 1891 05 2018

Name:

HCN:

Date of Birth:

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

EATING DISORDER SYMPTOMS				
			FREQUENCY	
	YES	NO	PER DAY	PER WEEK
Food Restriction	☐	☐		
Binge Eating	☐	☐		
Induced Vomiting	☐	☐		
Laxatives	☐	☐		
Diet Pills	☐	☐		
Diuretics	☐	☐		

CURRENT MEDICATIONS			
	NAME	DOSE	FREQUENCY
1			
2			
3			
4			
5			
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 Phosporus, Ferritin, B12

Systemic Examination

Authorizing Prescriber's Name:_____ Date:_____DD/MONTH/YYYY_____

Authorizing Prescriber's Signature:_____