SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

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

Young Adult Eating Disorders Program

Physician Referral

Fax to: 905-830-5979

Please print legibly. FORMS THAT ARE NOT COMPLETE OR NOT CLEARLY PRINTED WILL BE RETURNED.

IMPORTANT: Our program serves patients with **a BMI of 16 and above.** Patients with a BMI below 16 should NOT be referred.

Patient's Name: *(print first, last)*		
Date of Birth: _____ *(Patients must be between 18 and 25 years of age)*		
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:**
Name of Family Physician: *(print first, last)*		**Phone Number:**
Name of Emergency Contact: *(print first, last)*		
Relationship to Patient:		**Phone Number:**
Mailing Address: Street Name and Number Apartment City Province Postal Code		
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?)*

_____

SL1641_06 (10/13) "Child & Adolescent Mental Health" Review (10/16)

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

Weight Loss	Onset	Duration	Precipitating Factors
❑ No ❑ Yes _____ **kg**	_____		

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

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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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:** _____
Heart Rate	**supine**	**standing**	**Date taken:** _____

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: Katie Wilton
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 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 Name: *(print first, last)*	**Referring Physician Billing #:**
Referring Physician Signature:	**Date:** _____
Address: Street Number and Name Apartment City Province Postal Code	
Telephone Number:	**Fax Number:**
Are you? ❑ Family Physician ❑ Other *(specify)* _____	

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