SOUTHLAKE
REGIONAL HEALTH CENTRE

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

Child and Adolescent Eating Disorders Program Referral *(Patients up to the age of 17.5)*

Please print legibly

Patient's Name: *(print first, last)*				**Date of Birth:** dd / mm / yy
Address: Street Number and Name	Apartment	City	Province	Postal Code
Phone Number:	❑ can call this number	❑ can leave messages	❑ on voicemail	❑ with person
Alternate 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)*				
Phone Number:	❑ can call this number	❑ can leave messages	❑ on voicemail	❑ with person
Alternate 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:**
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		
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?)*

_____

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

Weight Loss	Onset	Duration	Precipitating Factors
❑ No ❑ Yes _____ **kg**	dd / mm / 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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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:** dd / mm / yy
Heart Rate	**supine**	**standing**	**Date taken:** dd / mm / yy
Oral Temperature	**F** **C**		**Date taken:** dd / mm / yy
Hydration	**poor** **fair** **good** **very good**		**Date taken:** dd / mm / 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 out-patient 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
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 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: *(print first, last)*	**Billing #:**
Signature:	**Date:** dd / mm / yy
Address: Street Number and Name Apartment City Province Postal Code	
Phone Number:	**Fax Number:**

Are you? ❑ Family Physician ❑ Paediatrician ❑ Other *(specify)* _____