

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: <i>(Print first, last)</i> _____			
DOB: <u>dd</u> / <u>mm</u> / <u>yy</u>	Age: _____	<input type="checkbox"/> Female	<input type="checkbox"/> Male
OHIP #: _____	Version Code: _____		
Account #: _____	Date of Admission: <u>dd</u> / <u>mm</u> / <u>yy</u>		

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

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

Weight Loss	Onset	Duration	Precipitating Factors
<input type="checkbox"/> No <input type="checkbox"/> Yes _____ kg	<u>dd</u> / <u>mm</u> / <u>yy</u>		

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

MENSES: <i>(if applicable)</i>	Menarche:
	Usual Cycle:
	Last Menstrual Period:
	Last Normal Menstrual Period:
	1° amenorrhea:
	2° amenorrhea / length:

MEDICATIONS:
Prescribed: <i>Name(s) & dose(s) & frequency</i>
Non-prescription: <i>Name(s) & dose(s) & frequency</i>

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

ECG & LAB WORK: <i>Please have all of the following completed and faxed to us at time of referral</i>										
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: <u>dd</u> / <u>mm</u> / <u>yy</u>		
Heart Rate	supine	standing	Date taken: <u>dd</u> / <u>mm</u> / <u>yy</u>		
Oral Temperature	F	C	Date taken: <u>dd</u> / <u>mm</u> / <u>yy</u>		
Hydration	poor	fair	good	very good	Date taken: <u>dd</u> / <u>mm</u> / <u>yy</u>

PRIOR MEDICAL DIAGNOSES AND/OR TREATMENT FOR THIS CONDITION AND/OR OTHER CONDITIONS	
Previous history of hospitalization for an Eating Disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>(If yes, when & where)</i> _____
Previous out-patient treatment for an Eating Disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>(If yes, when & where)</i> _____
Name of Healthcare Provider and tel. #: _____	
Other medical diagnoses: _____	

PRIOR PSYCHIATRIC DIAGNOSES AND/OR TREATMENT:	
<input type="checkbox"/> Suicidal behaviour	<input type="checkbox"/> Self Harm Behaviours _____
<input type="checkbox"/> Suicidal Ideation or Intent	<input type="checkbox"/> History of CAS involvement <input type="checkbox"/> OCD
<input type="checkbox"/> Borderline Personality Disorder	<input type="checkbox"/> Depression <input type="checkbox"/> History of Abuse <input type="checkbox"/> Sexual <input type="checkbox"/> Physical <input type="checkbox"/> Emotional
<input type="checkbox"/> Residential Treatment	<input type="checkbox"/> History of Legal trouble <i>(police involvement)</i>
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Substance Abuse <input type="checkbox"/> ETOH <input type="checkbox"/> Other _____

Please return all forms to: **Eating Disorder Program** **Attention: Intake Worker**
Southlake Health **Phone: (905) 895-4521 ext. 2825**
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 Health 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: <i>(print first, last)</i> _____	Billing #: _____
Signature: _____	Date: <u>dd</u> / <u>mm</u> / <u>yy</u>
Address: Street Number and Name _____ Apartment _____ City _____ Province _____ Postal Code _____	
Phone Number: _____	Fax Number: _____
Are you? <input type="checkbox"/> Family Physician <input type="checkbox"/> Paediatrician <input type="checkbox"/> Other <i>(specify)</i> _____	