

Adult Eating Disorders Program Referral for Assessment

Telephone: (613) 737-8885

Fax: (613) 737-8652

NOTE: Forms that are incomplete or not clearly printed will be returned

Date of Referral: _____

NOTE: PRIMARY CARE PROVIDER IS RESPONSIBLE FOR THE MEDICAL MONITORING OF THEIR PATIENT WHILE WAITING FOR ADMISSION AND POST DISCHARGE FROM THE EATING DISORDER PROGRAM.

Referring MD/NP Name (Print): _____

OHIP Billing No: _____

*Suggested Medical Monitoring Guidelines attached.

Primary Care Provider Name (Print): _____

OHIP Billing No: _____

I have read and accept the medical monitoring guidelines

Date of Last In-Person Visit with Referring MD/NP (Print): _____

Signature of GP or NP: _____

Patient's Name (print): _____

Gender Identity: Female Male Other

DOB: _____ (dd/mm/yy)

Address: _____

Health card Number: _____ Version Code: _____

Telephone Contacts:

Leave messages of a confidential/medical nature:

Language(s): English French

Home: _____ Yes No

Other: _____

Work: _____ Yes No

Cell: _____ Yes No

Name of other contact person: _____

Has the patient indicated specific concerns regarding confidentiality: Yes No
If yes, please clarify: _____

Telephone Number: _____

Presenting Problems:

- 1) _____
- 2) _____
- 3) _____

Current Medications (include name, dose, route, frequency):

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Eating Disorder Symptoms

Associated Mental Health Diagnoses:

Current Weight: _____ Height: _____ BMI: _____

	NO		YES		FREQUENCY	
					# PER DAY	# PER WEEK
Food Restriction						
Binge Eating						
Induced Vomiting						
Laxatives						
Diet Pills						
Diuretics						
Excessive Exercise						

Physical Exam, Bloodwork, Other Findings:

Substance Use:

Alcohol Cannabis Cocaine Opioids

Other: _____

List other Eating Disorder Programs/Mental Health Services you have currently referred the patient to: