Lakeridge Health

Pinewood
Centre & Mental
Health Services

CONFIDENTIAL EATING DISORDERS PROGRAM REFERRAL FORM

Phone: (905) 576-8711 ext. 4622 Fax: (905) 721-4843

The Eating Disorders Program provides outpatient services to adolescents (11-17 years) and adults 18 years and older with Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, Avoidant/Restrictive Food Intake Disorder, and Other Specified Feeding or Eating Disorder.
We do not accept referrals for weight loss or weight management, or for clients who have undergone gastric bypass surgery or any other form of bariatric surgery as the program does not offer these services.
This form is to be completed by a physician or nurse practitioner. We ask all referring physicians and nurse practitioners to provide medical/physical health care to clients while they are on the waiting list for treatment and during involvement in treatment.

LAST NAME	FIRST NAME		ADDRESS (street)				
ADDRESS (mailing address if different from above)			CITY/TOWN				POSTAL CODE
HOME TELEPHONE			WORK TELEPHONE				
HEALTH CARD NUMBER		VERSION CODE	SEX	D.O.B.	Day	Month	Year

1. **PRESENTING PROBLEM AND MAJOR CONCERNS** ***(What Is The Nature Of The Eating Disorder?)***

2. **CURRENT HEIGHT:** ____________ 3. **CURRENT WEIGHT:** ____________

4. **WEIGHT HISTORY** ***(Any Changes In Weight Over Time; Rapid Weight Loss)***

5. **PRESENCE OF** ***(include frequency and description where applicable)*:**

- ☐ Bingeing ____
- ☐ Vomiting ____
- ☐ Laxative/diuretic abuse ____
- ☐ Excessive exercise ____
- ☐ Restrictive eating or fasting ____
- ☐ Use of diet pills ____

6. **ASSOCIATED MEDICAL AND/OR MENTAL HEALTH ISSUES:**

7. **CURRENT MEDICATIONS:**

FAMILY PHYSICIAN or NURSE PRACTITIONER (Please print)	PHONE NO:	BILLING NO:
REFERRING PHYSICIAN or NURSE PRACTITIONER (If different from above) (Please print)	PHONE NO:	BILLING NO:
DATE:	SIGNATURE:	

Previous Case: ____________________ **FOR OFFICE USE ONLY**

Unique #: ______________ **Date Received:** ____________________________ **Initials:** ______________

Date Screened: ________________ **Initials:** ____________

Lakeridge Health

Pinewood
Centre & Mental
Health Services