Lakeridge Health

Mental Health and Pinewood Centre Program
Eating Disorders Program

850 King Street West Oshawa, Ontario L1J 2L5
905-576-8711 ext. 34622
Fax: 905-721-4843

Referral Form

Please print or type clearly
***** Please note that incomplete referral forms will be returned for completion *****

BEFORE COMPLETING THIS REFERRAL FORM PLEASE READ:

- The Eating Disorders Program provides outpatient services for youth and adults.
- For patients **under the age of 18**, we provide family based treatment. **We must have consent from the patient to communicate with the parent(s)/guardian(s).**

  The patient, _____, gives consent for the Eating Disorders Program at Lakeridge Health to communicate with the parent(s)/guardian(s) for the purposes of screening and booking appointments.

  ☐ YES (patient to sign and date):_____

  ☐ NO (provide reason):_____

  Parent/Guardian Name(s) _____
- Referral to the program is for consultation and treatment recommendations. Treatment will be offered if appropriate. Treatment is time limited and focussed on normalized eating and symptom reduction. This program is not suitable for everyone.
- A patient is appropriate for referral if you suspect that she/he has an eating disorder and has a **Body Mass Index (BMI) of 16 or more**.
- We do not offer inpatient or day hospital treatment. If you believe your patient requires intensive treatment or could in the foreseeable future, please refer to www.ocoped.ca for a list of intensive services in Ontario.
- **The Primary Health Care Provider is responsible for the medical monitoring of their patient while on the waiting list for service and while attending the Eating Disorders Program.** Patients must be medically stable to be a patient in our program. Please see included Medical Monitoring Form for additional information.
- You must include **current results of the following investigations** with the referral form:

☐ ECG with report ☐ CBC & Diff ☐ Electrolytes ☐ Calcium ☐ Magnesium	☐ Phosphate ☐ Glucose ☐ BUN ☐ Creatinine ☐ Lipids (if binge eating)	☐ ALT ☐ Alkaline Phosphatase	☐ Albumin ☐ Vitamin B12 ☐ TSH ☐ Ferritin

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Date of Referral:_____

Last Name:_____ First Name: _____

Date of Birth (D-M-Y):_____ Age:_____ Sex:_____

Address:_____ City:_____ Postal Code:_____

Main Telephone:_____ Other Telephone:_____

Health Card Number (with version code):_____

Presenting Problem(s):

Current Measured Height:_____ Current Measured Weight:_____ BMI:_____
(Please include growth charts for ALL patients under the age of 18)

Weight History (Any changes in weight over time; rapid weight loss):

Weight Control Methods (**MUST complete all areas below**):

	No	Yes	# Per Day	# Per Week
Food Restriction				
Binge Eating				
Induced Vomiting				
Laxatives				
Diet Pill/Substances				
Diuretics				
Excessive Exercise				

Associated Medical or Mental Health Issues:

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Current Medications:

Physical Exam/Positive Findings:

Supine HR:_____BP:_____
Standing HR:_____BP:_____

Referring Health Care Provider (complete below or stamp):

Name: _____
Address: _____
Telephone: _____
Fax: _____

Primary Health Care Provider (if other than referring):

Name: _____
Address: _____
Telephone: _____
Fax: _____

Does patient give consent for the Lakeridge Health Eating Disorders Program to speak to Primary Health Care Provider if not referring?

- ☐ Yes
- ☐ No

Thank you for your referral. Our staff will contact your patient directly for a telephone screening appointment. If you require any further information please do not hesitate to contact us.