BEFORE COMPLETING THIS REFERRAL FORM PLEASE READ:

- The Eating Disorders Program provides outpatient services for adolescents (11-17 years) and adults (18 years and older).

- 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:

Where symptoms include: food restriction, purging of any kind, fluid restriction, excessive exercise, insulin under-use, or use of any substance for weight loss purposes, please complete the following investigations:

- ECG with report
- CBC & Diff
- Electrolytes
- Calcium
- Magnesium
- Phosphate
- Glucose
- Urea
- Creatinine
- AST
- ALT
- GGT
- Alkaline Phosphatase
- Albumin
- Vitamin B12
- TSH
- Ferritin

Where the symptom is BINGE EATING ONLY, please complete the following investigations:

- ECG with report
- CBC & Diff
- Electrolytes
- FASTING glucose
- FASTING lipids
- Urea
- Creatinine
- AST
- ALT
- GGT
- Alkaline Phosphatase
- Vitamin B12
- TSH
- Ferritin
Referral Form

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

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 18 years of age and younger.)

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

Weight Control Methods:

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
<th># Per Day</th>
<th># Per Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food Restriction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Binge Eating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Induced Vomiting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laxatives</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diet Pill/Substances</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diuretics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive Exercise</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Associated Medical or Mental Health Issues:
Referral Form

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

Current Medications:

Physical Exam/Positive Findings:

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.