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

Adult Binge Eating Referral Form

For Patients under the age of 18, referral must be made by a PHCP on our regular 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, group treatment for adults with Binge Eating. The group runs for 20 weeks and is usually run once per year.
- Criteria for referral:
  - Age 18 or over
  - Recurrent binge eating occurring at least once per week for three months and resulting in marked distress
  - No compensatory behaviours (such as purging, laxatives) that could compromise medical stability
  - Able to commit to attending treatment group 2 hours per week for 20 weeks
- **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 group.** Patients must be medically stable to attend group. Please see included *Medical Monitoring Form* for additional information.

  For self−referral:

  ☐ I agree to follow up with my Primary Health Care Provider for medical monitoring while on the wait list and in treatment. Initial _____

  For PHCP referral:

  ☐ I agree to follow up with the patient for medical monitoring while on the wait list and in treatment.
- Please let us know of any changes to your/your patient's condition that may impact participation in this group.
- Once the referral is received, you/your patient will be contacted directly for a telephone screening.
- If the group is not the right level of treatment for you/your patient, we will notify you to discuss alternatives.

Referring Health Care Provider:		Primary Health Care Provider (if other than referring):	
Name:	_____	Name:	_____
Address:	_____	Address:	_____
Telephone:	_____	Telephone:	_____
Fax:	_____	Fax:	_____

Does patient give consent for the Lakeridge Health Eating Disorders Program to speak to Primary Health Care Provider if not referring? Yes ☐ No ☐

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Date of Referral: _____

Last Name: _____ First Name: _____

Date of Birth (D−M−Y): _____ Age: _____ Gender: _____

Address: _____ City: _____ Postal Code: _____

Main Telephone: _____ Other Telephone: _____

Health Card Number (with version code): _____

Reason(s) for Referral:

Current Measured Height: _____ Current Measured Weight: _____

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				

Medical and/or Mental Health Issues:

Current Medications and Doses:

Physical Exam/Positive Findings (if referral from health care provider):

MHREF0013

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NOTE TO PRIMARY HEALTH CARE PROVIDERS:
In order to assist us to provide the highest quality of care, please make copies of this form for use in your ongoing follow up of our shared client. Please fax a copy of this form to (905) 721−4843 after each medical appointment.

Medical Goals of Treatment for an Eating Disorder:

For Anorexia Nervosa:

- Normalization of eating patterns
- Cessation of bingeing, purging and excessive exercise behaviours (if applicable)
- Weight restoration to >90% Ideal Body Weight (IBW)
- Resumption/maintenance of menses

For Bulimia Nervosa

- Normalization of eating patterns
- Cessation of bingeing, purging and excessive exercise behaviours
- Maintenance of a healthy, stable weight

For Binge Eating Disorder

- Normalization of eating patterns
- Cessation of bingeing
- Stabilization of weight

Please collect the following information: ☐ **weekly** ☐ **bi−weekly** ☐ **monthly** ☐ **other** _____		
Client Name:	**Age:**	**Date of Visit:**
Weight: **kg**	**BP supine:**	**BP standing:**
LMP:	**HR supine:**	**HR standing:**

Other Recommended Investigations: Please **fax copies of results** when any of the following are ordered:

Every 2 weeks or prn (e.g. with purging, laxative abuse, or BMI less than 18)	**Once per month or prn:** (e.g. previous bradycardia (HR less than 60), purging and/or laxative abuse)	**As needed:** (e.g. with purging, laxative abuse, BMI less than 18, amenorrhea, growth chart deviation)	
Electrolytes	ECG	Calcium	Hormones
Blood Glucose		Magnesium	Bone Density
Renal Function		Phosphate	Bone Age X−ray
Amylase (if purging)		Albumin	Pelvic U/S

Primary Health Care Provider (print first, last): _____

Signature: _____ Date: _____