

Date of Referral: _____

EATING DISORDER PROGRAM REFERRAL FORM

Client's Name: _____ Female Male

Age: _____ D.O.B.: _____ / _____ / _____
Day Month Year

Address: _____ Postal Code: _____

Telephone: Home (807) _____ Business: (807) _____

Referring Physician: _____ Family Physician: _____

Parent(s) / Legal Guardian: _____

Other Contact Person: _____

Name	Relationship to Patient	Telephone Number
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Special Instructions Regarding Communications: _____

1. PRESENTING PROBLEM(S): (i) _____
(ii) _____
(iii) _____

2. WEIGHT: Present _____ (lb or kg) Highest _____ (lb or kg) Lowest _____ (lb or kg)
Date: _____ Date: _____ Date: _____

** If applicable please attach a copy of growth chart*

3. HEIGHT: Present _____ Date: _____

4. HISTORY OF PRESENTING PROBLEM:

5. WEIGHT CONTROL METHODS: (please check methods currently used by client and frequency)

METHOD	NO	YES	PER DAY	PER WEEK
Food Restriction				
Binge				
Vomiting				
Laxatives				
Diuretics				
Ipecac				
Diet Pills				
Exercise				

6. CHANGE IN MENSTRUAL PATTERN: (please describe)

7. RESULTS OF RECENT LAB WORK: (necessary for processing of referral)

Complete Blood Count:

Serum Electrolytes (including chloride):

Blood Urea Nitrogen:

Serum Creatinine:

EKG:

Other:

8. MEDICAL STABILITY:

BLOOD PRESSURE		HEART RATE		TEMPERATURE	LEVEL OF HYDRATION
Lying	Standing	Lying	Standing	(oral)	
Date:		Date:		Date:	Date:

9. MEDICATIONS:

Prescribed:

Non-Prescribed:

10. OTHER:

Previous hospitalization and/or treatment for presenting problem(s):

Additional Psychiatrist/Therapist(s):

Further Comments:

Who will be providing continued medical monitoring?

Please return referral form to:

St. Joseph's Care Group
Eating Disorder Program
P.O. Box 3251
Thunder Bay, ON P7B 5G7
Telephone: (807) 343-2400

Fax: (807) 343-9447