ST. JOSEPH'S CARE GROUP
SISTER MARGARET SMITH CENTRE
301 North Lillie Street, Thunder Bay, ON., P7C 0A6
Care Compassion Commitment
P: (807) 684-5100 F: (807) 622-1779

EATING DISORDERS PROGRAM – REFERRAL FORM

**** LAB WORK & ECG MUST ACCOMPANY REFERRAL (MOST RECENT WITHIN 3 MONTHS) ****

Date:

CLIENT INFORMATION: (please print)

Client Preferred Name: **Client Legal Name:**

Gender: **Pronouns:**

DOB (D/M/Y): _____ / _____ / _____ **AGE:** ___ **Health Card #** _____ **VC** ___

Phone: _____lv. msg? ☐ yes ☐ no **Cell:** _____lv. msg? ☐ yes ☐ no **Other:** _____ lv. msg? ☐ yes ☐ no

Address: _____ **City:** _____ **Postal Code:** _____

Email Address: _____ ok to email? ☐ yes ☐ no

Emergency Contact Person: _____ **Phone:** _____

If client is under 18, parent/caregiver(s) noted below will be the primary contact

Parent/Caregiver #1 Name: Phone: Email:

Parent/Caregiver #2 Name: Phone: Email:

MEDICAL & PSYCHIATRIC INFORMATION (for clients under 18, please send growth charts)

Eating Disorder Diagnosis: _____ When did symptoms start? _____

Current Height: _____ ☐ IN ☐ CM Current Weight: _____ ☐ LBS ☐ KG BMI: _____

Please note that our program is an **outpatient treatment program** that does not treat individuals whose eating disorders place them at high medical risk.
We do not treat patients who have a BMI less than 16 and/or severe eating disorder symptoms. Please consider referring these patients to a higher level of care.

Recent Weight loss (how much?) _____ Time frame of weight loss (weeks/months) _____

Lowest WT:_____ ☐ LBS ☐ KG age or year _____

Highest WT: _____ ☐ LBS ☐ KG age or year _____

Heart Rate: (lying down) _____ (standing) _____

Orthostatic BP: (lying down) _____ (standing) _____

Medical History: ☐ Diabetes ☐ Pregnant ☐ Amenorrhea ☐ History of amenorrhea ☐ Substance use ☐ Other/describe:

Current Medications:

Psychiatric History (please describe and/or attach any psychiatric supporting documents):

EATING DISORDER RELATED BEHAVIOURS

☐ **Food Restriction** (please describe):

☐ fasting: _____ ☐ calorie counting: _____

☐ portion control: _____ ☐ food rules/rituals: _____

☐ other: _____

☐ **Binge Eating**

Frequency: _____ describe: _____

☐ **Vomiting**:

Frequency: _____ describe: _____

☐ **Laxatives**:

Frequency: _____ describe: _____

☐ **Diuretics**:

Frequency: _____ describe: _____

☐ **Diet Pills**:

Frequency: _____ describe: _____

☐ **Exercising:**

Frequency: _____ describe: _____

☐ **Other:**

Frequency: _____ describe: _____

*****MANDATORY LAB WORK & ECG MUST ACCOMPANY REFERRAL*****

CBC; random glucose; CA; MG; PO4; Ferritin; CR; BUN; ESR or C-reactive Protein; TSH; ALT; AST; sodium; potassium; chloride; bicarbonate; microscopic urinalysis to include specific gravity

ECG – please provide a copy with this referral

☐ **Lab work is attached OR I confirm that lab work has been requested and will send once it becomes available**

REFERRING PHYSICIAN: (**NOTE** - all clients must have a GP, NP or walk-in clinic that will follow patient)

Referent Name: _____ **Address/Clinic:** _____ **Phone:** _____ **Fax:** _____

Primary Care Provider (if different from above)**:**_____ **Address/Clinic:** _____

☐ I authorize that the client is aware of and agreed to this referral

☐ I authorize that the client, if under the age of 18, is aware that parent(s)/caregiver(s) will be contacted to schedule an initial appointment and I have provided the necessary parent/caregiver contact information

☐ I understand that SMSC is an outpatient eating disorders service and that the client is required to be medically stable prior to referral completion

☐ I understand that SMSC is unable to assume responsibility for the primary medical care of this client and that ongoing care for the client is the responsibility of the primary care provider; including any hospitalization for medical stabilization

If you are unsure regarding the appropriateness of a referral, please contact us at 684-5100 ext. 5041

_____ _____

Referring Physician's Signature Date

Please fax this referral to (807) 622-1779