|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**: | **Health Card#** | | | | | **Version**: | |
| **Name**: | | | **DOB**: | **Gender**: | | | **Age**: |
| **Mailing Address**: | | | **911 Address**: | | | | |
| **Postal Code**: | | | Mail Correspondence accepted:  Yes  No | | | | |
| **Telephone Number** (primary):  Messages can be left?  Yes  No | | | **Telephone Number**(secondary):  Messages can be left?  Yes  No | | | | |
| **Referral Source**: | | | **Agency**: | | | | |
| **Phone:** | | | **Is client aware of this referral**?  Yes  No | | | | |
| **Emergency Contact (parental information if adolescent)**: | | | **Relationship**: | | | | |
| **Address**: | | | **Telephone Number**: | | | | |
| **Allergies:**  **Yes No**  **If yes, specify:** | | |  | | | | |
| **Family Physician**:  **Psychiatrist** : | | | **Phone**:  **Phone:** | | Last Seen:  Last Seen: | | |
| **Other Providers:** | | | | | | | |
| **Reason for Referral**: | | | | | | | |
| **Medication List:** | | | | | | | |
| **Has client received treatment/counselling for eating disorder in the past**?  Yes  No | | | | | | | |
| **Is family physician aware client is struggling with an eating disorder: Yes**  **No**  **Is there a diagnosis: BN AN EDNOS other:** | | | | | | | |
| **Are there any barriers to accessing service**  (Language, communication, physical, visual etc.)? | | Yes  No : **If yes, specify:** | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Identify Eating Disorder symptoms/concerns:**  Food Restriction  Yes  No Binge Eating  Yes  No  *Frequency*       *Frequency*  Vomiting  Yes  No Laxatives/diuretics  Yes  No  *Frequency*       *Frequency*  Diet Pills  Yes  No Exercising  Yes  No  *Frequency*       *Frequency*  Other  **Is the individual experiencing any health concerns such as**:  Absence of Menses Yes  No Cold Intolerance  Yes  No  *Frequency*       *Frequency*  Dizziness/light headedness  Yes  No Passing Out  Yes  No  *Frequency*       *Frequency*  Hair Loss  Yes  No ‘ Edema  Yes  No  *Frequency*       *Frequency*  Poor circulation in extremities  Yes  No Shortness of Breath  Yes  No  *Frequency*       *Frequency*  Dental erosion/caries  Yes  No Poor concentration/memory  Yes  No  *Frequency*       *Frequency*  Social isolation  Yes  No  *Frequency*  Other:  **Self Injury History**  Suicide attempt  Yes  No Comments  Self-harming  Yes  No Comments  Substance Abuse  Yes  No Comments  Other | | | |
| **Safety Risks**  Current or past charges:  Yes  No  History of harm to people/property:  Yes  No | | Safety Risk:  Yes  No  No Identified Risk:  Yes  No | |
| **Comments:** | | | |
| ***\*\*If Physician / Family Health Team Referral, complete the following:***  Current Weight:       Height:       BMI:  Recent Blood Work:  Yes  No Date Completed:  Abnormal findings? K+ Phos Gluc CR Urea Amylase other  Recent ECG  Yes  No Date Completed:  Recent Vital Signs: Temperature:       Sitting: HR:       BP:  Standing: HR:       BP: | | | |
| **\*\*\**If the above cannot accompany the referral please arrange for testing and forward results as this will reduce wait time for service***. | | | |
| **Psychiatric Issues / Diagnosis:** | | | |
| **Previous Hospitalization:**  Yes  No Comment: | | | |
| **Huron Perth Helpline and Crisis Response Team phone number provided?**:  Yes  No | | **1-888-829-7484** |
| **Individual given information on the importance of seeing her family physician for a physical? Yes**  **No** | | |

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**Fax the Completed Form to 519-357-1614.**