Alexandra Marine & General Hospital
Huron Outreach Eating Disorders Program

Date:	**Health Card#**	**Version**:

Legal Name (on health card): **Preferred name:**	**Gender**: ☐ M ☐ F ☐ Other Preferred pronoun: _____/_____	**Marital Status**:
Address: **Postal Code**:	**911 Address**: **Email address**: @	
Correspondence accepted: Mail ☐ Yes ☐ No Email ☐ Yes ☐ No	Date of Birth: / / DD / MM / YYYY	
Telephone Numbers (Primary): **Messages can be left?** ☐ Yes ☐ No	(Secondary): **Messages can be left?** ☐ Yes ☐ No	
Emergency Contact:	**Relationship**:	
Address:	**Telephone Number**:	
Primary Care Provider: **Psychiatrist:** **Other Service Providers:**	**Phone Number:** **Phone Number:** **Phone Number:**	
Previous client of our program? ☐ Yes ☐ No	**How long ago**?	
Allergies: ☐ **Yes** **No** ☐ **If yes, specify:**		
Are there any barriers to accessing service? ☐ Yes ☐ No : **If yes, specify:** (Language, communication, physical, visual etc.)		
Referral Source:	**Agency**:	
Phone:	**Fax #:**	
If you are referring an adolescent, parent/guardian information must be provided and they must be aware of the referral and advised their participation in treatment is required. Parent/Guardian: Telephone #: Aware of referral? ☐ Yes ☐ No		
Presenting Problem: ☐ Bulimia Nervosa ☐ Anorexia Nervosa ☐ Avoidant/Restrictive Food Intake Disorder ☐ Other Eating Disorder ☐ Binge Eating Disorder ☐ Concern with disordered eating		

Eating Disorder Behaviours (please check all that apply)

Behaviour	Frequency # per day	# days per week
☐ Binge Eating:		
☐ Vomiting		
☐ Laxative Use		
☐ Diet Pills		
☐ Diuretics		
☐ Excessive Exercise		
☐ Food Restriction	Estimated daily caloric intake:	

Agency and School-Based Referral:

Has the primary care provider been notified of the referral?

Has an appointment with primary care provider been scheduled?

Huron Outreach Eating Disorders Program does not provide medical monitoring

Primary Care Provider Physical Examination Findings:

Plan of Care of Monitoring and Treating:

Current Weight: Height: BMI: If underweight please identify goal weight.

How much weight has individual lost over what period of time?

Other Mental Health Diagnoses:

Are other clinicians / services providing counselling?:

Current safety factors: Assess and check all that apply below and provide details.

☐ Passive suicidal thoughts ☐ Active suicidal thoughts ☐ History of suicide attempt

☐ Substance use ☐ Thoughts to harm others ☐ History of violence/aggression

☐ Current intentional self-harm behaviours ☐ Behaviour influenced by hallucinations/delusions

Other:

Details:

Other Psychosocial Issues:

☐ **Marital/custody** ☐ **Abuse** ☐ **Financial** ☐ **Housing** ☐ **Work**

☐ **Situational Crisis** ☐ **Grief/Loss** ☐ **Charges Pending** ☐ **On Trial**

Are there any safety risks, past charges, episodes of harm towards others, or property damage that staff should be aware of in delivering services? ☐ Yes ☐ No

If yes, specify:

Fax the Completed Form to 519-357-1614.