Alexandra Marine & General Hospital
Huron Outreach
Eating Disorders Program

Date:	**Health Card#**	**Version**:
Name:	**Gender**: ☐ M ☐ F	**Marital Status**:
Mailing Address:	**911 Address**:	
Postal Code:		
Mail Correspondence accepted: ☐ Yes ☐ No	**Birth date**:	**Age**:
Telephone Number (Home):	(cell/work/other):	
Messages can be left? ☐ Yes ☐ No	Messages can be left? ☐ Yes ☐ No	
Emergency Contact (parental information if adolescent):	**Relationship**:	
Address:	**Telephone Number**:	
Next of Kin (parental information if adolescent):	**Relationship:**	
Address:	**Telephone Number:**	
Custodial Arrangements (if applicable):		
Family Physician:	**Psychiatrist**:	
Phone #:	**Phone #:**	
Is family physician aware client is struggling with an eating disorder: Yes ☐ No ☐		
When was the last time client was seen by their family doctor:		
Allergies: ☐ Yes No ☐ If yes, specify:		
Are there any barriers to accessing service (Language, communication, physical, visual etc.)?	☐ Yes ☐ No : **If yes, specify:**	
Referral Source:	**Agency**:	
Phone:	**Is client aware of this referral**? ☐ Yes ☐ No	
Has client received treatment/counselling for eating disorder in the past? ☐ Yes ☐ No		
When?	**Where?**	
Are there any safety risks staff should be aware of in delivering service? ☐ Yes ☐ No		
If yes, specify:		

Reasons for Referral: Established eating disorder diagnosis?
Eating disorder behaviours?

What is the Diagnosis? AN BN EDNOS Other:

Symptoms: (ie what are the identified concerns)

Frequency of restriction
Frequency of bingeing
Frequency of vomiting
Frequency of laxatives/diuretics
Frequency of over-exercising

Shortness of Breath
Passing Out
Falling
Cold Intolerance
Weight loss >30% in 3 months

Is the individual experiencing any health concerns related to the eating disorder?

Psychiatric Issues (other diagnoses) and previous hospital admissions?:

Current Medications and Dosages:

History	No	Yes	When	Comments
Suicidal Attempts				
Other self-harm behaviours				

Does individual struggle with substance use? Yes ☐ No ☐
Specify:

RISK ISSUES

Are there any legal aspect to this referral with: **CAS** ☐ **Lawyer** ☐ **Probation** ☐ **Parole** ☐ **Police** ☐
If yes, specify:

Has the individual ever engaged in episodes of harm to people or damage to property (fire setting, vandalism etc)
YES ☐ **NO** ☐ If yes, specify:

Criminal Charges	No	Yes	Charge	When	Disposition & Comments
Current Charges	☐	☐			
Past Charges	☐	☐			

Individual given crisis intervention phone number: ☐ Yes ☐ No Crisis Intervention #1-888-829-7484

Individual given information on the importance of seeing her family physician for a physical? Yes ☐ **No** ☐

Fax the Completed Form to 519-357-1614.