|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date**: | **Health Card#** | | | | **Version**: | |
| **Legal Name (on health card)**:  **Preferred name:** | | **Gender**:  M  F  Other  Preferred pronoun:      / | | | | **Marital Status**: |
| **Mailing Address**: | | | **911 Address**: | | | |
| **Postal Code**: | | | **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 | | | | |
| **Substitute Decision Maker**: | | **Relationship**: | | | | |
| **Address:** | | **Telephone Number**: | | | | |
| **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 | | | | | | |

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| --- | --- | --- |
| **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:** | | |
|  | | |

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