|  |  |  |
| --- | --- | --- |
| **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 [ ]  NoNo 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 otherRecent 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** [ ]  |

Page 2 of 2

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