Eastern Health

Child/Women's Health Program

Adolescent Eating Disorders Referral for Assessment (Part I)

Telephone: (709) 777-4963 Fax Referral to: (709) 777 -4726

AS6350 2132 03 2020

Name

HCN

Date of Birth:

Information for Referral Sources:

1. Part I and Part II are required to be completed **in full**. Incomplete forms will not be processed.
2. This form is used for screening purposes. People will be contacted directly for an assessment appointment.
3. The Family Physician or Nurse Practitioner is responsible for the medical monitoring of their patient while waiting for the initial assessment by the Adolescent Medicine Pediatrician. Please refer to the Assessment Guidelines for Hospitalization of Patients with Eating Disorders.
4. A person must be between 12-17 years to be followed by the Adolescent Medicine Team.
5. The use of this form is for consultation and treatment for eating disorders in the adolescent population.

Section I (to be completed by Referral Source) **Referral Date:**

REFERRAL SOURCE: *Affix Rubber Stamp if Applicable*

Name: _____

Telephone: _____ Fax: _____

Address: _____

_____

PATIENT INFORMATION

Address: _____

_____

Telephone Numbers: _____ _____ Can a message be left? ☐ Yes ☐ No

History/Reason(s) for Referral:

Additional Medical and Mental Health History (please include allergies, medical and/or psychiatric illness, substance use, history of suicidal/homicidal ideation, and any other relevant information):

Name: _____ Date: DD/MONTH/YYYY

Signature: _____

Eastern Health

Child/Women's Health Program

Adolescent Eating Disorders Referral for Assessment (Part II)

Telephone: (709) 777-4963 Fax Referral to: (709) 777 -4726

AS6350 2132 03 2020

Name

HCN

Date of Birth:

Section II (to be completed by Physician or Nurse Practitioner) Date:___DD/MONTH/YYYY_____

EATING DISORDER SYMPTOMS:

	YES	NO	Frequency
Food Restriction	☐	☐	
Binge Eating	☐	☐	
Induced Vomiting	☐	☐	
Laxatives	☐	☐	
Diet Pills	☐	☐	
Diuretics	☐	☐	

CURRENT MEDICATIONS:

1.
2.
3.
4.
5.
6.
7.

Exercise History:

PHYSICAL EXAMINATION

Current Height		Pulse (lying X 5 minutes)	
Current Weight		Blood Pressure (lying X 5 minutes)	
BMI		Pulse (standing X 2 minutes)	
Maximum weight and date		Blood Pressure (standing X 2 minutes)	
Minimum weight and date		Temperature	
Weight Loss		Last Menstrual Period ☐ Primary amenorrhea ☐ Secondary Amenorrhea	

Systemic Examination:

Please complete and attach ECG and Blood work including: CBC, Ferritin, TSH, BUN, Creatinine, Amylase, Glucose, Calcium, Magnesium, Phosphate, Potassium, Chloride, and Sodium

Name: _____ Date:____DD/MONTH/YYYY_____

Signature: _____