

**The Eating Disorder Program
The Hospital for Sick Children**

Dear Doctor:

Thank-you for your referral to the Eating Disorder Program at The Hospital for Sick Children. The Eating Disorder Program at The Hospital for Sick Children provides assessment and treatment for adolescents who suffer from the symptoms of anorexia nervosa and bulimia nervosa. The Eating Disorder Program has both an inpatient and an outpatient clinic, that provides medical, nutritional and psychosocial treatment. We assess adolescents who are **17.5 years old or younger**.

In order to assess your patient appropriately, the Form 14's [signed by patient and parents], referral form, ECG and lab work [listed in referral form] all need to be completed and returned to me.

Once all this information has been received from your office, the patient will be booked for an assessment as soon as possible. The waiting time for assessment can be quite lengthy at times. You will be notified directly if more urgent recommendations are required in order to manage the safety and health of your patient.

Please note that we do not accept patient care responsibility until we see the patient directly. If your patient is ultimately followed in our program we look forward to working with you in their ongoing care. If there is any significant change in your patient's medical status you should contact me as soon as possible.

If you have any questions please do not hesitate to contact me at (416) 813-7195.

Sincerely,

Heather Graham, B.Sc.(Psych)
Intake Co-ordinator
Eating Disorder Program
The Hospital for Sick Children

Please check off when completed:

- Referring physician has informed patient and family of this referral and reason for this referral.
- Form 14's (2 copies; one for information to be given to HSC from the family physician; one for information to be given from HSC to the family physician)
- Lab work and ECG (please return at time of referral)

**The Eating Disorder Program
The Hospital for Sick Children**

Today's Date: _____ Health Card # _____

Patient's Name: _____ DOB: _____/_____/_____
Day Month Year

Address: _____ Postal Code: _____

Parent/Guardian Names: _____

Phone #: (Res) _____ (Bus) _____ (Cell) _____

Who does patient reside with: Both Parents Mother Father Guardians

Who has custody of patient: Joint Mother Father Guardians Ward of CAS

Step-Parent(s) Name: _____

Phone #: (Res) _____ (Bus) _____ (Cell) _____

Referring Physician: _____ Specialty: _____

Address: _____

Phone #: _____ FAX # _____

Email Address: _____

Family Doctor/Paediatrician: _____

Please note: Please print or type all information. Please complete all sections. Your patient will not be assessed at the Eating Disorder Program at The Hospital for Sick Children until all this information has been received by us.

*
COMMENTS: _____

Has this patient been referred to your Regional Eating Disorder Centre? YES [] NO []

If YES, what was the outcome of the referral? _____

Has this patient been referred to any other treatment facility/person for her/his eating disorder at the same time that they are being referred to The Hospital for Sick Children? YES [] NO []

If YES, where are they being referred? _____

Please return entire form to:
The Eating Disorder Program / 7A
Attention: Heather Graham, Intake Co-ordinator
The Hospital for Sick Children
555 University Avenue, Toronto, ON M5G 1X8

Phone: (416) 813-7195

Fax: (416) 813-7867

PRESENTING PROBLEM(S):

DIAGNOSIS:

<p>1.</p> <p>2.</p> <p>3.</p>	
-------------------------------	--

WEIGHT & HEIGHT: Please provide a growth chart or complete growth history in addition to below:

Please record Current Weight Date taken:	Please record Current Height Date taken:
Kg Lbs	CM Ft/In
Previous Weights: Lowest kg / lbs	Previous Weights: Highest kg / lbs
Date of lowest wt:	Date of highest wt:

Weight Loss	Onset	Precipitating Factors	Duration

WEIGHT CONTROL METHODS

FREQUENCY
Per Day Per Week

	No	Yes	Per Day	Per Week
Food Restriction				
Binge				
Vomiting				
Laxatives				
Diuretics				
Ipecac				
Diet Pills				
Exercise				

MENSES: Menarache: _____

Usual Cycle: _____

Last Menstrual Period: _____

Last Normal Menstrual Period: _____

1° amenorrhea: _____

2° amenorrhea / length: _____

ECG & LAB WORK: Please have the following lab work completed and faxed to us at time of referral

X	Sodium	X	Potassium	X	Chloride
X	Glucose	X	Urea	X	Calcium
X	Phosphate	X	ALT	X	Total Protein
X	Albumin	X	Creatinine	X	TSH
X	AST			X	CBC, Diff., Platelets
X	ESR	X	Electrocardiogram		

MEDICAL STABILITY: **VERY IMPORTANT...PLEASE FILL OUT COMPLETELY**

Blood Pressure	lying	standing	Date taken
Heart Rate	lying	standing	Date taken
Oral Temperature	F C		Date taken
Hydration	poor fair good very good		Date taken

MEDICATIONS:

Prescribed: Name(s) & dose(s)
Non-prescribed: Name(s) & dose(s)

PRIOR MEDICAL DIAGNOSES AND/OR TREATMENT FOR THIS CONDITION AND/OR OTHER CONDITIONS

Previous history of hospitalisation for an Eating Disorder Yes No

If yes, when & where _____

Name of responsible physician and tel.#: _____

Previous Outpatient Treatment for an Eating Disorder Yes No

If yes, when & where _____

Name of healthcare provider and tel.#: _____

Other medical diagnoses: _____

PRIOR PSYCHIATRIC DIAGNOSES AND/OR TREATMENT:

<input type="checkbox"/> Suicidal behaviour	<input type="checkbox"/> Self Harm Behaviours
<input type="checkbox"/> Suicidal Ideation or Intent	<input type="checkbox"/> History of CAS involvement
<input type="checkbox"/> OCD	<input type="checkbox"/> Borderline Personality Disorder
<input type="checkbox"/> Depression	<input type="checkbox"/> History of Abuse <input type="checkbox"/> Sexual <input type="checkbox"/> Physical <input type="checkbox"/> Emotional
<input type="checkbox"/> Residential Treatment	<input type="checkbox"/> History of Legal trouble (police involvement)
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Substance Abuse <input type="checkbox"/> ETOH <input type="checkbox"/> Other _____

Please provide a *separate* formal referral note with detailed psychiatric information outlining history, previous treatment, admissions residential treatment, history of self harm behaviours, and history of suicidal behaviour.