Eastern Health
Mental Health and Addictions Program

Adult Eating Disorders Referral For Assessment (Part I)

Telephone: (709) 777-2041 Fax referral to:(709) 777-2042

AS5770 1891 05 2018

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 which will determine appropriate level of care. (Outpatient, HOPE Program or Inpatient Treatment)
3. The Family Physician or Nurse Practitioner is responsible for the medical monitoring of their patient while waiting for inpatient admission and post-discharge. The Family Physician or Nurse Practitioner is required to medically monitor their patient while participating in the Outpatient or HOPE Program. Please refer to suggested medical monitoring guidelines as needed.
4. A person must be 15 years of age or older to participate in the HOPE Program.
5. Primarily, people over 18 years of age will be admitted to the inpatient treatment program at the Health Science Center.
6. Consultation and treatment for anorexia nervosa, bulimia nervosa and other specified feeding and eating disorders (OSFED) are provided by the Adult Eating Disorder Program.

SECTION I (To be completed by Referral Source)

REFERRAL DATE: DD/MONTH/YYYY

PATIENT INFORMATION

Allergies: ☐ No Known

Telephone:	Can a message be left? ☐ Yes ☐ No		
Street Address	City	Province	Postal Code

MENTAL HEALTH HISTORY

Reason(s) for referral:

1. _____
2. _____
3. _____

Additional Mental Health and Addictions History *(Please include other psychiatric illnesses, substance use, history of suicidal/homicidal ideation, and any other relevant information):*

Is the client able to participle in a group-based program? ☐ Yes ☐ No

Name:_____ Date:DD/MONTH/YYYY

Signature:_____

Eastern Health
Mental Health and Addictions Program

Adult Eating Disorders Referral For Assessment (Part II)

Telephone: (709) 777-2041 Fax referral to:(709) 777-2042

AS5770 1891 05 2018

Name:

HCN:

Date of Birth:

SECTION II (To be completed by Physician/Nurse Practitioner)

EATING DISORDER SYMPTOMS				
			FREQUENCY	
	YES	NO	PER DAY	PER WEEK
Food Restriction				
Binge Eating				
Induced Vomiting				
Laxatives				
Diet Pills				
Diuretics				

CURRENT MEDICATIONS			
	NAME	DOSE	FREQUENCY
1			
2			
3			
4			
5			
6			
7			

Exercise History

PHYSICAL EXAMINATION

BMI		Temperature	
Current Height		Last Menstrual Period	
Current Weight		Blood Pressure (Lying x 5 minutes)	
Weight Loss		Blood Pressure (Standing x 2 minutes)	
Maximum Weight		Pulse (Lying x 5 minutes)	
Minimum Weight		Pulse (Standing x 2 minutes)	

Systemic Examination

Authorizing Prescriber's Name:_____ Date:_____DD/MONTH/YYYY_____

Authorizing Prescriber's Signature:_____