Child & Adolescent Mental Health Care Program
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Children's Hospital
London Health Sciences Centre

CHILD & ADOLESCENT MENTAL HEALTH CARE PROGRAM
EATING DISORDERS REFERRAL FORM

Name of child or adolescent:_____ Sex: M F

Date of Birth: ____/____/____ Age: _____ Health Card Number: _____

Year Month Day

Name of parent/guardian: _____

Phone number(s)-Home: _____ Work: _____ Cell_____

Address: _____

_____

Who does patient reside with? ☐ Both parents ☐ Mother ☐ Father ☐ Guardian(s)

Custody Status: ☐ Joint ☐ Mother ☐ Father ☐ Guardians ☐ Ward of CAS

Referring Physician: _____(Specialty) _____

Address: _____

Phone # _____ FAX # _____

PRESENTING PROBLEM(S):

1. _____

2. _____

3. _____

Onset:_____

Precipitating factors:_____

VERY IMPORTANT
WEIGHT & HEIGHT: *PLEASE PROVIDE A GROWTH CHART & COMPLETE GROWTH HISTORY IN ADDITION TO BELOW*

Highest Weight: Date taken:	**Lowest Weight:** Date taken:	**Current Weight:** Date taken:	**Current Height:** Date taken:

WEIGHT CONTROL METHODS **FREQUENCY**

			PER DAY	**PER MONTH**
Food Restriction	☐ **No**	☐ **yes**		
Binge	☐ **No**	☐ **yes**		
Vomiting	☐ **No**	☐ **yes**		
Laxatives	☐ **No**	☐ **yes**		
Diuretics	☐ **No**	☐ **yes**		
Diet Pills	☐ **No**	☐ **yes**		
Exercise	☐ **No**	☐ **yes**		

MENSES: Menarche: _____

Usual Cycle: _____

Last Menstrual Period: _____

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

Sodium	Potassium	Chloride	Albumin
Random Glucose	Urea	Calcium	ALP
Phosphate	ALT	Electrolytes	Total Bilirubin
AST	CBC	Creatinine	Magnesium
Magnesium	Phosphate	Amylase	TSH

Electrocardiogram (ECG) completed date: _____

MEDICAL STABILITY: **VERY IMPORTANT…PLEASE FILL OUT COMPLETELY WITH CURRENT INFORMATION**

Blood Pressure	lying	standing	Date taken
Heart Rate	lying	standing	Date taken
Oral Temperature	C/F		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 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:

☐ Suicidal behaviour
☐ Suicidal ideation
☐ OCD
☐ Depression
☐ Substance Abuse ☐ ETOH ☐ Other _____
☐ Self Harm Behaviours _____
☐ History of CAS involvement
☐ History of Abuse ☐ Sexual ☐ Physical ☐ Emotional
☐ Anxiety Disorder

COMMENTS_____

_____

_____

_____