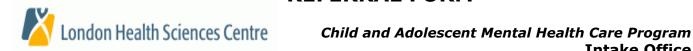
REFERRAL FORM



Intake Office

Ph #: (519) 667-6640

Please Fax Referral to: (519) Total # of pages (including this page	•					
Age criteria: Outpatients ages 15 and under Eating Disorders - consultation and treatm						5 yrs
*For referrals regarding EATING DI eating disorders referral form.	SORDE	RS: please co	ntact our office	and we w	vill fax	(an
Name of child/adolescent:				Sex:	М	F
Date of Birth:	Age:	Health C	ard Number			
Please provide name of parent/guardian	:				_	
Phone number(s)-Home:		_ Work:		_		
Mailing Address:						
Has the parent/guardian been in	formed	of the refe	ral? Yes	No		
If not, please do so before submi	itting th	is referral.				
If not, please do so before submi	_		h child/family: _			
		Role wit				
If not, please do so before submi		Role wit	mber:			
If not, please do so before submi		Role wit	mber:			
If not, please do so before submit Referral Agent: Phone Number: Mailing Address:		Role wit	mber:			