The BC Provincial Specialized Eating Disorders Program –Internal Referral Form

Internal referrals are accepted from the mental health teams in BCCH for BC residents 8 to 17 years of age with a diagnosed eating disorder of Anorexia Nervosa, Bulimia Nervosa or OSFED.

To speed up the process, please provide as much information as possible in all sections. Call 604-875-2106 if you have any questions.

Please note: Information enclosed on and within this form will be shared with the designated secondary or tertiary services in the patient's health region.

Assessment Option

Referrer's preference: ☐ Team to Team* ☐ Full assessment

* Select the "*Team to Team*" option if you prefer an expedited virtual consultation with the care team involved. This option is suited for re-referrals or complex cases.

Referring Program

☐ P2 Adolescent Psych ☐ P2 CAPE ☐ P1 Child Psych

☐ Other BCCH MH Services: _____ (SPECIFY) ☐ BCCH OPD Clinics: _____ (SPECIFY)

Referrer's info: _____ (LAST NAME) _____ (FIRST NAME) _____ (INITIAL) _____ (OFFICE PHONE #) _____ (OFFICE PHONE #)

Referrer's title: _____ Referrer's signature: _____

Patient Information

Legal Names: _____ (PLEASE PRINT) (FIRST) _____ (MIDDLE) _____ (LAST) _____ (PREFERRED) Phone: _____

Sex: _____ (ASSIGNED AT BIRTH) Gender: _____ (PREFERRED PRONOUN(S)) MRN: _____ (❁MANDATORY) DOB: _____ (dd/ mm/ yy)

Address: _____ (APT. #. STREET NAME) _____ (CITY) _____ (POSTAL CODE)

Primary Language: ☐ English ☐ Other –describe: _____ ☐ Interpreter Required

Special Observation Level: ☐1:1 Supervision ☐ Constant Obs. ☐ Other/please specify: _____

☐ Certified: _____ (DATE OF EXPIRY) Other notes: _____

Parents or Guardians Information

Caretaker #1 Name: _____

Relationship to patient: _____

Phone: _____ (HOME) _____ (CELL)

Email: _____

☐ Is aware of this referral ☐ Is agreeable

Caretaker #2 Name: _____

Relationship to patient: _____

Phone: _____ (HOME) _____ (CELL)

Email: _____

☐ Is aware of this referral ☐ Is agreeable

Eating disorder related information

Behaviour: ☐ Restriction ☐ Bingeing ☐ Vomiting ☐ Laxatives/diuretics use ☐ Over-exercising

Height _____ inch/cm Weight _____ lb/kg BMI _____ Date weight taken _____/___/___ DD / MM / YY

Lowest weight _____ lb/kg age or year: _____ ♦ Highest WT _____ lb/kg Age or year: _____

Heart rate: lying _____ standing _____ ♦ BP: lying _____ standing _____ LMP _____

Please provide a copy of the following lab work with this referral (Check each box to confirm)

☐ ECG ☐ CBC ☐ Lytes (+glucose) ☐ CA ☐ MG ☐ PO4 ☐ Ferritin ☐ CR ☐ BUN ☐ ESR ☐ TSH

Current psychological or psychiatric treatment(s)

Please include any current consultations or ongoing care report(s):

CARE PROVIDER	NAME & PHONE NUMBER
☐ Psychiatrist	
☐ Psychologist	
☐ EAP	
☐ Therapist/Counselor	
☐ Social Worker	

Medical History and Issues

History of ☐ Diabetes ☐ Pregnancy ☐ Substance Use ☐ Allergies

Current list of Medication(s):

Previous Medication(s) and Timeline:

Psychiatric Current and history

Describe any psychiatric issues or previous admissions:

Current psychiatric issues:
- ☐ Aggression
- ☐ Suicidal ideation
- ☐ Suicidal attempts
- ☐ Domestic abuse
- ☐ Risk taking behaviours
- ☐ Active substance use

Thank you for your time