



**Up to 17 years of age:**

**BC Children's Hospital**  
Provincial Specialized  
Eating Disorders Program  
P3-212 / 4500 Oak Street  
Vancouver, BC V6H 3N1

Tel: (604) 875-2010

Fax: (604) 875-2099



**17 years & older:**

**St. Paul's Hospital**  
Provincial Specialized  
Eating Disorder Program  
4N – 1081 Burrard Street  
Vancouver, BC V6Z 1Y6

Tel: (604) 806-8347

Fax: (604) 806-8631

**Important: Please ensure that your patient is referred/ connected to a *regional program* in their area before a referral is made to these Specialized Programs.**

**Referral history:**

1: Has this patient had **previous regional program involvement**? If yes provide:

Date: \_\_\_\_\_ Program name \_\_\_\_\_

2. Is this patient on a waitlist for a regional program?

No  Yes (Date referred) \_\_\_\_\_

3. Is this a re-referral to Provincial EDP?

No  Yes (Date of last contact with Provincial EDP) \_\_\_\_\_

Please note  
**Please note**

★ Although the referral form is long, it has been created to be **user-friendly** and **efficient** in nature.

★ We require **ALL** information requested in order to best assess your patient's treatment needs.

Sorry – but we are **unable to process incomplete referrals** and

they will be returned to you.

# Referral Form

## Provincial Specialized Eating Disorders Programs

For the assessment of individuals who struggle with Anorexia Nervosa and/or severe Bulimia Nervosa and who may require provincial specialized treatment services:



Adult Services (17 years [out of high school] and older) = St. Paul's Hospital.



Child & Adolescent Services (currently registered in high school) = BC Children's Hospital.

### IMPORTANT NOTE

\*\* One primary medical professional **must** be identified on this form. The primary care provider will be responsible for following their patients regularly.

## REFERRING PROFESSIONAL \*\*

PLEASE PRINT CLEARLY

Are you:  GP/Family Doctor  
 Pediatrician  
 Psychologist  
 Psychiatrist  
 Regional Program  
 Other (specify) \_\_\_\_\_

Are you the primary care provider?  Yes  No

MSP Billing # \_\_\_\_\_

Name

\_\_\_\_\_ (last) \_\_\_\_\_ (first) \_\_\_\_\_ (middle initial)

Office phone # ( )

Office Fax # ( )

Address Street:

City:

Postal Code:

## Other PRIMARY CARE PROVIDER \*\*

Name

\_\_\_\_\_ (last) \_\_\_\_\_ (first name)  GP/Family Doctor  
 Pediatrician  
 Psychologist  
 Psychiatrist  
 ED Program  
 Other (specify) \_\_\_\_\_

Office phone # ( )

Office Fax # ( )

MSP Billing #

Address Street:

City:

Postal Code:



## ***Eating disorder related information***

Date of last visit to GP: \_\_\_\_\_ Current HT \_\_\_\_\_ in / cm Current WT \_\_\_\_\_ lbs / kg

Lowest WT \_\_\_\_\_ lb / kg age or year: \_\_\_\_\_ Highest WT \_\_\_\_\_ lb / kg age or year: \_\_\_\_\_

### **Eating disorder related behaviours:**

**Restricting (past 6 months)**

Yes  No  
 Hx of Restricting, please describe:

**Self reported (daily intake):**

less than equiv. of 1 meal/day  
 1 meal/day  
 2 meals or >/day (including snacks)

**Restricting fluids:**

No  
 Yes - If yes, please describe

**Binge/Purge behaviour (over past 3 months)**

Binge episodes:  Yes  No  Hx but not currently  
 Frequency (check one)  Daily  Weekly  Monthly  
 Amount (check one)  1-3x  3-5x  >5x  
 Other info:

Vomiting  daily; frequency  1-3x;  3-5x;  >5x  
 Twice a week  Less than once per week  
 Blood with vomiting  Yes  No Other info:

Laxatives  Yes  No

**If yes, type(s) used**

Frequency:  daily  weekly  monthly **Approximate amount:**  1-10  10-20  >20

History of Laxative Abuse. Describe: \_\_\_\_\_  
 \_\_\_\_\_

Diuretics  Yes  No

**If yes, type & frequency**

Hx When:

Appetite Suppressants  Yes  No

**If yes, type & frequency**

Hx When:

Metabolism boosters  Yes  No

**If yes, type & frequency**

Hx When:

Chewing and spitting  Yes  No

Hx When:

Other: please describe

Exercise  Yes  No  Hx of over-exercising

If yes, type, frequency & duration

# Medical History

**Allergies**     Yes     No

**If yes, specify allergies** (i.e., food, medications, seasonal, or other):

**List medications used to treat allergies:**

Past medical admission     Yes     No    If yes, please describe

If male: Erectile dysfunction?     Yes     No

If female: Amenorrhoea?     **Yes, date of last period:** \_\_\_\_\_     No     Never menstruated

Hysterectomy:     Yes     No

Hormonal replacement? Including contraceptives     Yes     No

If yes, Yes Dates : \_\_\_\_\_

If, Yes Dates : \_\_\_\_\_

Pregnant     Yes    Week of pregnancy at referral \_\_\_\_\_     No

Name of OB/GYN & Phone # & Fax #

**\* Consultation reports required**

Diabetes     Yes, describe \_\_\_\_\_     No    Age of Onset \_\_\_\_\_

Insulin dependent?     Yes     No

Last seen by endocrinologist: Date:

**\* Consultation reports required**

Name/Tel # & Fax #

GI Disorders (e.g., Crohn's, Celiac Disease, IBS)     Yes     No

Please specify Dx & Tx received

**Current Medications, including vitamins, or supplements:**    *Please list type and dosage*


**Lab work**    \* **Please provide a copy of the following with this referral (mandatory):**

• CBC    • Lytes (+glucose)    • CA    • MG    • PO4    • Ferritin    • CR    • Urea    • TSH    • K+    • BUN

\* **For BCCH, additional labs are required:**    • AST    • ALT    • INR

• ECG - Please send copy to EDP

Bone Density:    • For **BCCH (requested)**    Do you have a copy?     Yes     No    Ordered?     Yes     No

• For **SPH (optional)**     Yes – date: \_\_\_\_\_  
 No

Growth Curves • for **BCCH (REQUIRED)**

**Psychiatric history:**  
**\* Psychiatry consults or reports required**

Previous **eating disorders** treatment?  Yes  No If yes, describe (when, where)

Previous **psychiatric admissions**?  Yes  No If yes, describe (when, where)

**\* Please attach discharge summary with this referral.**

***CURRENT psychological or psychiatric treatment: \*Consultation reports required***

- Mental Health Team  No Location & #: \_\_\_\_\_
- Psychiatrist  No Name & #: \_\_\_\_\_
- Psychologist  No Name & #: \_\_\_\_\_
- EAP  No Name & #: \_\_\_\_\_
- Therapist/Counselor  No Name & #: \_\_\_\_\_
- Other Describe: \_\_\_\_\_

Current suicidal thoughts?  Yes  No **If yes**, please describe treatment received.

Does this person have a plan?  Yes  No **If yes**, please describe.

Suicide attempts Current?  Yes **If yes**, how many times? \_\_\_\_\_ times  No  
 In the past?  Yes **If yes**, how many times? \_\_\_\_\_ times  No

Has this person received treatment?  No  Yes – if yes, describe:

Self-Harm  Yes  No Past  Yes  No

If yes, please describe and treatment received:

Substance Use	Frequency	Amount	Cessation Date
<input type="checkbox"/> Tobacco <input type="checkbox"/> No			
<input type="checkbox"/> Alcohol <input type="checkbox"/> No			
<input type="checkbox"/> Cannabis <input type="checkbox"/> No			
<input type="checkbox"/> Methamphetamine <input type="checkbox"/> No			
<input type="checkbox"/> Cocaine <input type="checkbox"/> No			
<input type="checkbox"/> Prescription meds <input type="checkbox"/> No			
<input type="checkbox"/> Other, please describe			

Treatment received? Describe: