Referral Form: the British Columbia Provincial Specialized Eating Disorders Programs

Who can be referred?

BC residents with a diagnosed eating disorder of Anorexia Nervosa, Bulimia Nervosa or Otherwise Specified Feeding and Eating Disorder who are followed by a primary care provider (i.e. GP or Nurse Practitioner).

Who can make this referral?

Referrals are accepted from **the regional eating disorders programs.*** If you are not a regional program, please make a referral to the regional program in the patient's area instead. For a current list of regional programs please see KeltyEatingDisorders.ca/finding-help/programs or call the Kelty Mental Health Resource Centre at 604-875-2084.

*In **the absence of a regional program**, referrals will be accepted from a medical professional, mental health teams in other primary or secondary services and community care providers.

What are the programs?

BC Children's Provincial Specialized Eating Disorders Program

- Provincial tertiary program for children & adolescents offering assessment, inpatient, & outpatient services
- For patients age 16 and under
- Visit BCchildrens.ca/our-services/mental-health-services/eating-disorders

The Provincial Adult Tertiary and Specialized Eating Disorders Program at St. Paul's

- Provincial tertiary program for adults offering assessment, inpatient, outpatient services, and intensive day/residence programs
- For patients age 17 and older
- Visit mh.providencehealthcare.org/programs/provincial-adult-tertiary-eating-disorders-program

Looking Glass Residence (LGR) –Eating Disorders Program

- Provincial residential program for youth and young adults
- For medically stable patients age 16 to 24
- Visit BCchildrens.ca/our-services/mental-health-services/looking-glass-residence
- LGR is a voluntary residential program. The client must be medically and psychiatrically stable, AND in agreement with this referral. The BMI (criteria) must be 15+ at the time of referral and will be supported to reach a BMI of 16+ for entry into the residential program. A per diem cost will apply for residents age 19 years and older. **For full criteria see the Looking Glass website above.**

How to submit this form?

On the next page, select one of the three programs based on patient's situation. The contact information of each Intake Coordinator is listed below. Please call if you have any questions or concerns. Fax the fully completed form and supporting documents to the corresponding fax number listed below:

BC Children's Hospital	Phone: 604-875-2106	Fax: 604-875-2099
Provincial Adult Tertiary at St. Paul's Hospital	Phone: 604-806-8654	Fax: 604-806-8631
Looking Glass Residence	Phone: 604-829-2585 (Ext. 2)	Fax: 604-829-2586

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. This referral may be redirected to one of the other services in the continuum of care in BC if deemed more appropriate to meet the patient's needs.

To speed up the process, please make sure that you provide as much information as possible in all sections. Thank you!

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Select a program

☐ **BC Children's Hospital** 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.

☐ **Provincial Adult Tertiary at St. Paul's Hospital**

☐ **Looking Glass Residence**

Referring Program or Medical Professional Information

Your name: _____ (LAST) _____ (FIRST) _____ (INITIAL) _____ (OFFICE PHONE #) _____ (OFFICE FAX #)

Address: _____ (STREET) _____ (CITY) _____ (POSTAL CODE)

Your position: ☐ A Regional Program –Specify: _____

☐ Psychologist ☐ Psychiatrist ☐ GP/Family Doctor (Provide MSP billing# below)

☐ Pediatrician ☐ Other: _____

GP/Family Doctor: If different than above _____ (Name) _____ (MSP Billing #)

Case Manager: If different than above _____ (Name) _____ (Email) _____ (Phone #)

Please sign here: _____

Patient Information

Legal Names: (PLEASE PRINT) _____ (First) _____ (Middle) _____ (Last) _____ (Preferred)

Sex: _____ (Assigned at birth) Gender: _____ (Preferred pronoun(s)) BC PHN#: _____ ❁Mandatory DOB: _____ (DD / MM/ YY)

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

Address: _____ (Apartment # - Street) _____ (City) _____ (Postal Code)

Phone: _____ (Home) _____ (Cell) _____ (WORK (if applicable)) _____ (Preferred for message)

Parents or Guardians Information

Caretaker #1 Name: _____ Caretaker #2 Name: _____

Relationship to patient: _____ Relationship to patient: _____

Phone: _____ (Home) _____ (Cell) Phone: _____ (Home) _____ (Cell)

Email: _____ Email: _____

Please indicate:

☐ The patient is aware of this referral ☐ The patient is agreeable to referral

☐ The parent/guardian is aware of this referral ☐ The parent/guardian is agreeable to referral

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Current psychological or psychiatric treatment(s) ❁Mandatory

Provide ongoing care reports or current consultations

☐ Mental Health Team Location & #: _____

☐ Psychiatrist Name & #: _____

☐ Psychologist Name & #: _____

☐ EAP Name & #: _____

☐ Therapist/Counselor Name & #: _____

Eating disorder related information ❁ Mandatory

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

Lowest WT _____ 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)

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

Eating disorders related behaviours

Please describe and include frequency of activities using **D**=daily; **W**=weekly; **M**=monthly

D	W	M	Behaviour
☐	☐	☐	Restriction
☐	☐	☐	Bingeing
☐	☐	☐	Vomiting
☐	☐	☐	Laxatives/diuretics use
☐	☐	☐	Over-exercising

Medical History and Issues

History of ☐ Diabetes ☐ Pregnancy ☐ Substance Use ☐ Allergies

Describe any medical issues:	Current medication(s):

Psychiatric history ❁Mandatory

Describe any psychiatric issues or previous admissions:

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

Please email Jaafar.Aghajanian@CW.BC.CA for feedback about this form.

Thank you for your time!!!