UHN Toronto General Hospital

Office Use Only:
Date Received:_____

REFERRAL FORM

INTENSIVE EATING DISORDERS PROGRAM

This form is used for screening purposes and to contact patients directly for an appointment for initial assessment. It is necessary that ALL the information is complete. **Incomplete or illegible forms will be returned. All referred patients need to be assessed by our program.**

We provide intensive treatment to individuals with moderately to extremely severe eating disorders. This includes individuals with significantly low body weight, and/or binge-eating and/or purging symptoms multiple times per week, and/or severe food restriction. **We do not provide treatment for Binge Eating Disorder.**

Treatment is voluntary and patients must have goals consistent with treatment and be willing to participate in treatment.

Patient's Name: _____
Last First Middle Initial

Gender: ☐ **Woman** ☐ **Man** ☐ **Trans Woman** ☐ **Trans Man** ☐ **Non-binary** ☐ **Other:**_____

DOB: _____ **(dd/mm/yy)** **PATIENTS MUST BE 17 YEARS OF AGE OR OLDER**

Address: _____
Street Address

_____
City **Province** **Postal Code**

Phone Number: Primary: (____)_____ **Secondary:** (____)_____

E-mail: _____

Health Card Number:_____**Version Code:** _____

REFERRING PHYSICIAN/NP

Full Name	**Primary Care Provider?** ☐ **YES** ☐ **NO**
Address	
Phone Number	**Fax Number**
Provider Billing # (For OHIP)	**Provider E-mail address:**
Name and Address of Primary Care Provider (if not referral source):	

PRESENTING PROBLEMS:

- ☐ **Bulimia Nervosa**
- ☐ **Anorexia Nervosa**
- ☐ **Avoidant/Restrictive Food Intake Disorder (ARFID)**
- ☐ **Other Eating Disorder:** _____

***Current Weight:**_____ *** Weight Trajectory:** _____

*** Height:**_____ *** BMI:** _____

PLEASE ONLY FAX THE REFERRAL FORM ONCE TO AVOID DUPLICATION. IF YOU NEED TO FOLLOW UP ON A REFERRAL, PLEASE DO NOT HESITATE TO CONTACT INTAKE AT THE PHONE NUMBER LISTED BELOW.

Eating Disorder Behaviours				
	NO	**YES**	**FREQUENCY (#) PER DAY**	**# DAYS PER WEEK**
Binge Eating				
Vomiting				
Laxative Use				
Diet Pills				
Diuretics				
Excessive Exercise				
Food Restriction			**Estimated daily caloric intake:**	

Other Mental Health Diagnoses (please list):

If the patient is being referred from another intensive eating disorder program, please indicate the reason for referral to our program:

Physical Examination – Please attach recent blood work and ECG findings; *please indicate positive findings

Notes
Potassium*
Hemoglobin*
Recent ECG (include copy)

CURRENT MEDICATIONS

Accessibility Needs
YES NO If yes, please describe:

Interpreter Needed
YES NO If yes, language:

OTHER HEALTHCARE PROVIDERS (Please include any relevant reports from other specialists)

Full Name
Address
Telephone Number

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- **Has a referral been made to Credit Valley Hospital or The Ottawa Hospital's intensive eating disorder programs at this time? Yes ☐ No ☐**
- **Has the patient previously received intensive eating disorder treatment? Yes ☐ No ☐ (include any relevant assessments and treatment/discharge summaries)**
- **Is the patient willing to be contacted for research studies? Yes ☐ No ☐**

☐ **I confirm that I am the patient's MRP and will be involved in this patient's care, providing ongoing health care needs leading up to, during and after this patient receives treatment at UHN. I will review notes and recommendations sent by UHN for this patient. I understand that UHN is not able to provide ongoing medical and psychiatric care to patients referred to the Eating Disorders Program.**

☐ **I confirm the patient is aware of and has agreed to this referral.**

☐ **I confirm that the patient is aware that our program provides intensive treatment (5-7 days per week) for eating disorders and the patient is interested in these services.**

Physician's signature:_____ Date: _____

Please return this form to:

Eating Disorders Program
Toronto General Hospital
200 Elizabeth Street, ES 7 - 425
Toronto, ON M5G 2C4
Tel: (416) 340-3041
Fax: (416) 340-3430
Email: intake.eatingdisorders@uhn.ca