RVH Royal Victoria Regional Health Centre Referral Form Child & Youth Outpatient Services Eating Disorders Program www.rvh.on.ca	PATIENT NAME: _____ DOB: _____ HRN:_____ (addressograph)

Please print legibly. FORMS THAT ARE NOT COMPLETE OR NOT CLEARLY PRINTED WILL BE RETURNED

Date of Referral: ____/____/____	
Patient's Name: (print first, last)	
Date of Birth: ____/____/____ **(Patient must be under 17.5 years of age)**	
Address:	
Telephone Number Home:	**Alternate Phone Number:**
Permission to leave message: ☐ Yes ☐ No	
Health Card #:	**Version Code**:
Parent/Guardian Name:	
Telephone Number:	**Relationship to Patient:**
Reason for Referral and presenting problem: For example: **(eg. purging, weight loss, restricting, excessive exercise)**	

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WEIGHT & HEIGHT: Please provide a growth chart or complete growth history in addition to below	
Current Weight Date : ___/___/___ _____kg / lb	**Current Height Date : ___/___/___** _____ cm/ ft-in
Highest Previous Weight: **Date of highest wt: ___/___/___** _____kg / lb	
Lowest Previous Weight: **Date of lowest wt: ___/___/___** _____kg / lb	

WEIGHT CONTROL METHODS	**NO**	**YES**	**WEIGHT CONTROL METHODS**	**NO**	**YES**
Food Restriction			Ipecac		
Binge			Diet Pills / Supplements		
Vomiting			Exercise		
Laxatives			Other (please specify)		
Diuretics					

MENSES:	Menarche: ☐ **Yes** ☐ **No** ☐ **N/A**
	Last Normal Menstrual Period:

MEDICATIONS:
Prescribed: Name(s) & dose & frequency
Non-prescription: Name(s) & dose & frequency

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ECG & LAB WORK: Please have all of the following completed and faxed to us at time of referral

Sodium	Potassium	Chloride	Glucose	Urea	Ca	Mg	Phosphate	ALT	Amylase	FSH
Total Protein	Albumin	Creatinine	TSH	CBC, Diff, Platelets	ESR	Free T4			ECG	

MEDICAL STABILITY: **VERY IMPORTANT…PLEASE FILL OUT COMPLETELY WITH CURRENT INFORMATION**

Blood Pressure	Supine	standing	Date taken: ___/___/___
Heart Rate	Supine	Standing	Date taken: ___/___/___

Throat/Mouth: ☐ dental erosions ☐ dental caries ☐ parotid enlargement

Resp: ☐ shortness of breath

CVS: ☐ history of heart problem ☐ chest pain ☐ heart palpitations ☐ arrhythmias

CNS: ☐ memory loss ☐ poor concentration ☐ insomnia

GI/GU: ☐ gastric discomfort ☐ early satiety ☐ delayed gastric empyting

☐ gastroesophageal reflux ☐ frequency of BM _____ ☐ constipation ☐ bleeding

Sexual Maturity Rating _____

Integument ☐ lanugo hair ☐ hair loss ☐ skin discoloration ☐ poor healing

PRIOR MEDICAL DIAGNOSES AND/OR TREATMENT FOR THIS CONDITION AND/OR OTHER CONDITIONS

☐ Previous history of hospitalization for an Eating Disorder ☐ No ☐ Yes (if yes, when & where _____

☐ Previous Outpatient Treatment for an Eating Disorder ☐ No ☐ Yes (if yes, when & where _____

Name of provider: _____
tel. #: _____

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PRIOR PSYCHIATRIC DIAGNOSES AND/OR TREATMENT:

☐ Suicidal behaviour ☐ Self Harm Behaviours

☐ Suicidal Ideation or Intent ☐ History of CAS Involvement

☐ Borderline Personality Disorder ☐ Depression ☐ OCD

☐ Residential Treatment ☐ History of Legal trouble (police involvement) ☐

☐ Anxiety Disorder ☐ Substance Abuse ☐ ETOH ☐ Other _____

☐ History of Abuse ☐ Sexual ☐ Physical ☐ Emotional

Referring Provider Name:	
Signature	Date:
Address:	
Phone:	Fax:
Office Private:	

PLEASE NOTE: Please complete all sections. Your patient cannot be assessed until all information has been received.

Clinic Use Only

Received:	
Booked:	
Confirmed:	

Child and Youth Outpatient Services
Phone: 705-738-9090 Ext. 47230
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