St. Joseph's Care Group
Sister Margaret Smith Centre
301 N. Lillie St.,
Thunder Bay, Ontario P7B 5G7

Date of Referral: _____

EATING DISORDER PROGRAM REFERRAL FORM

Client's Name:_____ **Health Card #**_____ **VC**___ Female □ Male □

Age: _____ D.O.B.: _____ / _____ / _____
Day Month Year

Address: _____ Postal Code:_____

Telephone: Home (807)_____ Business: (807)_____

Referring Physician:_____ Family Physician:_____

Parent(s) / Legal Guardian:_____

Other Contact Person:_____
Name **Relationship to Patient** **Telephone Number**

Special Instructions Regarding Communications:_____

_____

1. **PRESENTING PROBLEM(S):** (i) _____

(ii) _____

(iii)_____

2. **WEIGHT:** Present_____(lb or kg) Highest_____(lb or kg) Lowest _____(lb or kg)

Date:_____ Date:_____ Date:_____

** If applicable please attach a coy of growth chart*

3. **HEIGHT:** Present _____ Date:_____

4. **HISTORY OF PRESENTING PROBLEM:**

5. **WEIGHT CONTROL METHODS:** (please check methods currently used by client and frequency)

METHOD	NO	YES	PER DAY	PER WEEK
Food Restriction				
Binge				
Vomiting				
Laxatives				
Diuretics				
Ipecac				
Diet Pills				
Exercise				

Please turn over.....

6. **CHANGE IN MENSTRUAL PATTERN:** (please describe)

7. **RESULTS OF RECENT LAB WORK:** (necessary for processing of referral)

Complete Blood Count:

Serum Electrolytes (including chloride):

Blood Urea Nitrogen:

Serum Creatinine:

EKG:

Other:

8. **MEDICAL STABILITY:**

BLOOD PRESSURE		**HEART RATE**		TEMPERATURE	LEVEL OF HYDRATION
Lying	Standing	Lying	Standing	(oral)	
Date:		Date:		Date:	Date:

9. **MEDICATIONS:**

Prescribed:

Non-Prescribed:

10. **OTHER:**

Previous hospitalization and/or treatment for presenting problem(s):

Additional Psychiatrist/Therapist(s):

Further Comments:

Who will be providing continued medical monitoring?

Please return referral form to:

St. Joseph's Care Group
Eating Disorder Program
Sister Margaret Smith Centre
301 N. Lillie St.,
Thunder Bay, ON P7C 0A6
Telephone: (807) 684-5100 Fax: (807) 622-1779