Regional Eating Disorders Program: Client Referral Form

In the continuum of care for eating disorders treatment on Vancouver Island, this referral form is shared by all Island Health Outpatient Eating Disorder Programs. Inclusion criteria may vary by program (see below boxes).

The following are generalized Exclusion criteria:

a) The client is actively suicidal
b) Non-eating disorder psychiatric disorders account for decreased food intake (i.e. thought disorders with delusions around food)
c) Alcohol or substance misuse is the primary presenting problem

Recognizing there is complex comorbidity in this population, contact the Regional Coordinator - Crystal Frost for further discussion if needed 250-519-5390 X 36925

Please read the following guidelines carefully – For the most current program information/Referral Form, check *Pathways* with the Divisions of Family Practice

Referring to Central Island Child & Youth Eating Disorders Program:

 Clients up to and including 19 years of age with confirmed or suspected eating disorder as outlined in the DSM V: Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED), Avoidant Food Intake Disorder (ARFID) and Other Specified Feeding & Eating Disorder (OSFED)
 Referrals are accepted from General Practitioners, Nurse Practitioners & Pediatricians for those 13-19 years of age
 Those 12 years of age & under require a Pediatrician referral.
 All other health care professionals wishing to refer, please liaise with a primary care practitioner on referral completion. If this is not feasible, please contact the Eating Disorders Program at the phone number below.
 Referrals are accepted from Geography 2 including the following regions: Ladysmith, Nanaimo, Oceanside, Alberni Valley, West Coast

Fax referral to: 250-716-1854
Phone Number: 250-618-9962

Referring to Central Island Adult Eating Disorders Program:

 Clients 19 years of age and older with confirmed or suspected eating disorder as outlined in the DSM V: Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED), Avoidant Food Intake Disorder (ARFID) and Other Specified Feeding & Eating Disorder (OSFED)
 Referrals are accepted from General Practitioners and Nurse Practitioners
 All other health care professionals wishing to refer, please liaise with a primary care practitioner on referral completion. If this is not feasible, please contact the Eating Disorders Program at the phone number below.
 Referrals are accepted from Geography 2 including the following regions: Ladysmith, Nanaimo, Oceanside, Alberni Valley, West Coast

Fax referral to: 250-739-5879
Phone Number: 250-739-5880 X 56117

Referring Clients to North Island Eating Disorders Program (Youth & Adults):

☐ Clients with confirmed or suspected eating disorder as outlined in the DSM V: Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED) and Other Specified Feeding & Eating Disorder(OSFED)

 Referrals are accepted from General Practitioners, Nurse Practitioners and Pediatricians

 All other health care professionals wishing to refer, please liaise with a primary care practitioner on referral completion. If this is not feasible, please contact the Eating Disorders Program at the phone number below.

Referrals are accepted from Geography 1 regions: Comox Valley, Strathcona, North Island

Comox Valley Fax: 250-331-5903

Phone Number: 250-331-5900 X 65325

Cell: 250-204-0674

Campbell River Email Referral to: EatingDisorderClinicCR@islandhealth.ca

Cell Number: 250-204-0413

Referring Clients to Cowichan Valley Adult Eating Disorders Program:

☐ Clients 19 years of age and older with confirmed or suspected eating disorder as outlined in the DSM V: Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED), Avoidant Food Intake Disorder (ARFID) and Other Specified Feeding & Eating Disorder (OSFED)

 Referrals are accepted from General Practitioners, Nurse Practitioners and Pediatricians

 All other health care professionals wishing to refer, please liaise with a primary care practitioner on referral completion. If this is not feasible, please contact the Eating Disorders Program at the phone number below.

 Referrals are accepted from Shawnigan Lake, Duncan, Chemainus, Lake Cowichan , North Cowichan, Mill Bay, Ladysmith

Email Referral to: EatingDisorderClinicCowichan@islandhealth.ca

*For youth, initial referral should go through Child & Youth Mental Health Fax 250-715-2789.

Please note: Eating Disorder Program – South Vancouver Island is operated under the Ministry of Children & Family Development. There is a separate referral form located on *Pathways* with the Divisions of Family Practice.

To connect with the Regional Eating Disorders Coordinator call: 250-519-5390 xtn 36925 or email: crystal.frost@islandhealth.ca

Where are you referring to? (Select one):

☐ Central Island Child & Youth Eating Disorders Program/ Fax referral form to: 250-716-1854

☐ Central Island Adult Eating Disorders Program / Fax referral form to: 250-739-5879

☐ North Island Eating Disorders Program
Comox Valley Fax referral form to: 250-331-5903
Campbell River Email referral for to: EatingDisorderClinicCR@islandhealth.ca

☐ Cowichan Valley Eating Disorders Program
Email referral form to: EatingDisorderClinicCowichan@islandhealth.ca

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Referring Primary Care Provider Information – All patients must have a GP, NP, or Walk-In Clinic that will follow them. The Information provided will be used for triaging purposes.

Date _____

Doctor's Name (First) _____ Doctor's Name (Last) _____

Office Phone _____ Office email address _____

Office Fax _____ Dr Office Stamp:

Office Address _____

City _____

Postal Code _____

Client Information

Is client aware and in agreement of this referral for eating disorder services Yes ☐ No ☐
If Youth, is the parent also aware Yes ☐ No ☐

Legal Last Name _____ Legal First Name _____

Middle Names(s) _____ Preferred Name _____

Date of Birth _____

Gender ☐Male ☐Female ☐Non-Binary ☐Trans ☐ Other _____

BC PHN _____

Street Address _____

City / Postal Code _____

Client Phone Number (home) _____ Cell/other: _____
OK to leave voicemails? Yes ☐ No ☐ OK to leave voicemails? Yes ☐ No ☐

Email address: _____

If referring for youth, Parent Name and Contact _____
OK to leave messages Yes ☐ No ☐

Are you referring to another service in conjunction with this referral? Yes☐ (Specify:)_____No☐

Eating Disorder Related Information – to be completed by primary care provider

Measured Height _____In ☐ / cm ☐ Measured Blinded Weight: _____lbs ☐ / kg ☐
Please send growth chart if under 18 years of age

Any weight loss in the past 3 months Yes ☐ Amount_____No ☐

Any weight loss in the past 6 months Yes ☐ Amount_____No ☐

Heart Rate Resting:_____Sitting: _____

Orthostatic BP Resting:_____Sitting:_____

Fear of Weight Gain Yes ☐ No ☐

Restriction Yes ☐ No ☐
Eating less than 1 meal equivalent/day ☐ _____
Eating less than 2 meal equivalent/day ☐ _____
Eating less than 3 meal equivalent/day ☐ _____

Over-Exercise Yes ☐ No ☐ Current # hours/day _____

Self Induced Vomiting Yes ☐ No ☐
How many time per day _____
How many days per week _____
Blood in emesis Yes ☐ No ☐

Medications for Weight Loss Yes ☐ No ☐

Laxative abuse ☐ Type and frequency _____
Insulin ☐ Details _____
Ipecac ☐ Details _____
Stimulants ☐ Details _____
Diet Pills ☐ Details _____
Diuretics ☐ Details _____
Thyroid meds ☐ Details _____

Binge Eating (objectively large amount eaten within any 2 hour period that feels out of control)

Yes ☐ No ☐ How many time per day _____ How many days per week _____

Medical History - to be completed by primary care provider

Amenorrhea Yes ☐ No ☐ Date of last period _____

If amenorrheic > 6 months, please order DEXA/BMD Scan and forward results

Birth Control Pills Yes ☐ No ☐
Pregnant Yes ☐ No ☐ Week of pregnancy at referral _____
Diabetes (insulin dependent) Yes ☐ No ☐ Details _____
GI Disorder (e.g. Crohn's, Celiac, GERD) Yes ☐ No ☐ Details _____
Substance/ETOH Misuse Yes ☐ No ☐ Details _____
Other Medical Concerns (please specify) _____
_____

Current Medications (please list type & dosage) _____
_____

Confirmed Allergies _____

***Mandatory Labwork & ECG Must Accompany Referral – please forward current results:**
CBC, Random Glucose, Na, K+, Cl, Bicarbonate, Ca, Mg, PO4, Ferritin, B12, Cr, BUN, AST, ALT, Alk Phos, TSH, Microscopic urinalysis to include specific gravity (LH, FSH, estradiol if genetically female, testosterone if genetically male)
ECG – For Baseline

Attached ☐
Requisition given to client ☐

Psychiatric History

Please describe any psychiatric symptoms of concern, or current diagnoses

_____

Self Harm Yes ☐ No ☐ Please describe _____

Suicidal Ideation Yes ☐ No ☐ Current or Past Attempts (when & how) _____

_____

Previous hospitalization or tertiary care admissions related to mental health or eating disorder concerns

_____

Perceived readiness for eating disorder treatment _____

Currently working with other therapists or clinicians Yes ☐ No ☐
If yes, names of Clinician/Therapist(s) _____

Physician/NP DSM 5 Diagnosis
- Anorexia Nervosa, Restricting type (AN/R) ☐
- Anorexia Nervosa, Binge/Purge type (AN/BP) ☐
- Bulimia Nervosa ☐
- Avoidant Restrictive Food Intake Disorder (ARFID) ☐
- Binge Eating Disorder (BED) ☐
- Other Specified Feeding & Eating Disorder (OSFED) ☐

Please include any recent pertinent consults/assessments and a summary note of your concerns

Routine Medical Monitoring

1. Regular supportive meeting to check-in regarding meals, eating disorder behaviours, and medical symptoms
    a. BLIND (backwards) weight, with no mention of numbers or body appearance, is recommended to avoid triggering relapse or worsening of symptoms
    b. Postural vital signs (lie supine x 5 minutes then take BP and HR. Stand x 2 minutes then take BP and HR)

**The Central Island Child & Youth Eating Disorders Program can provide regular monitoring of weight and vitals as indicated*

2. Routine investigations: ECG and bloodwork including CBC, electrolytes, Ca, Mg, PO4, kidney function, liver function and random glucose.

NOTE: Frequency of visits and investigations depends on symptoms and clinical judgement (for example, frequency of purging or restriction with rapid weight loss needs close monitoring (q 1-2 weeks), whereas patients with less severe behaviours can be monitored less frequently (q 4-8 weeks). Please see the Eating Disorders Toolkit for Primary Care Practitioners: https://keltyeatingdisorders.ca/wp-content/uploads/2017/05/Eating-Disorders-Toolkit-for-PCP-2018.pdf

Disclaimer

☐ I understand that the eating disorder program is an outpatient eating disorders service and is unable to assume responsibility for the primary medical care of this client. Ongoing primary care is the responsibility of the Primary Care Provider.

Primary Care Providers Signature_____ Date _____