St. Joseph’s Healthcare Eating Disorders Clinic

St. Joseph’s West 5th Campus
100 West 5th Street
Level 1, Block D, Room D125
Hamilton, Ontario L8N 3K7

Michele M. Laliberte, Ph.D. (Clinical Lead)
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Debbie Bang, RN, MHSc (Program Manager)
Jennifer Crooks (Program Admin Asst.) x. 33433

INTAKE COORDINATOR:
Seana Jackson-Brown, 905-522-1155 x. 33561
Fax # 905-540-6574

BEFORE COMPLETING REFERRAL FORM PLEASE READ:

- Referral to the program is for consultation and treatment recommendations. Treatment will be offered if appropriate. **This program is not suitable for everyone.**

- A patient is appropriate for referral if you suspect that she/he has an eating disorder and has a Body Mass Index (BMI) of 16 or more.

- St. Joseph’s Hospital Eating Disorders Clinic is an outpatient program. Our Transition Aged Program (TAP) offers individual Cognitive Behaviour Therapy – Enhanced (CBT-E) to patients between 16 and 22 years of age. Group treatment is available to all patients and is also CBT-based. **We do not offer inpatient treatment or day treatment at this time.** If you believe that your patient requires intensive treatment or could in the foreseeable future, please begin a referral to: The Homewood Health Centre in Guelph (for BMI 15+), Toronto General Hospital Eating Disorder’s Program, or the Credit Valley Program in Mississauga.

- **You must** include current results of the following investigations with the referral form:

  Where symptoms include: food restriction, purging of any kind, fluid restriction, excessive exercise, insulin under-use, or use of any substance for weight loss purposes, please complete the following investigations:

  | □ ECG with report | □ Phosphate | □ AST | □ Albumin |
  | □ CBC & Diff      | □ Glucose   | □ ALT | □ Vitamin B12 |
  | □ Electrolytes    | □ Urea      | □ GGT | □ TSH |
  | □ Calcium         | □ Creatinine| □ Alkaline Phosphatase | □ Ferritin |
  | □ Magnesium       |            |      |         |

  Where person is **BINGE EATING ONLY**, please complete the following investigations:

  | □ ECG with report | □ FASTING lipids | □ ALT | □ Vitamin B12 |
  | □ CBC & Diff      | □ Urea         | □ GGT | □ TSH |
  | □ Electrolytes    | □ Creatinine   | □ Alkaline Phosphatase | □ Ferritin |
  | □ FASTING glucose | □ AST          |      |         |

Eating Disorders Clinic
St. Joseph’s Healthcare
Referral Form

If you would like to refer a patient to the program, please fully complete the following three pages and return by fax to 905-540-6574 to the attention of Seana Jackson-Brown, Intake Coordinator. Please ensure to attach the completed blood work and ECG. Incomplete referrals will not be processed.

Family Physician: ____________________________ Date of Referral: _______/_______/_______

Address: __________________________________________________________________________________

Phone: ______________________ Back Line: ______________________ Fax:______________________

Physician’s Billing Number: ________________________ Signature: ______________________________

Patient Last Name: __________________________ First: ______________________ Initial: ______

Address: _______________________________________________________________________________________

__________________________________________ Number & Street

___________________________________________ City, Postal Code

HC#: ______________________ VC: ______

Date of Birth: _______/_______/_______ Age: _______ Gender: Female ( ) Male ( )

Contact Information:

Home: ____________________________ Cell: ____________________________

Email Address: ____________________________

HAS THE PATIENT INDICATED ANY SPECIFIC CONCERNS REGARDING CONFIDENTIALITY: Yes ( ) No ( )

If yes, please clarify: ________________________________________________________________

Please indicate how the patient would prefer to be contacted:

For phone calls: Home ( ) or Cell ( )

Do we have permission to leave a detailed voicemail?: Yes ( ) No ( )

For written communication: Mail to Home Address ( ) or Email ( )
Current Symptoms (check all that apply): Please ask the patient if you are uncertain

(    ) Restricting Food Intake (comments): ____________________________________________

(    ) Binge Eating (frequency): ____________________________________________________

(    ) Compensating for Food Intake by (include frequency):

(    ) vomiting: ____________________ (    ) abuse of thyroid meds: ____________________

(    ) laxatives: ____________________ (    ) insulin restriction: _______________________

(    ) ipecac: ____________________ (    ) diuretics: _________________________________

(    ) extreme exercise: ____________ (    ) other: _________________________________

(    ) diet pills/herbal weight loss remedies: __________________________________________

(    ) Extreme distress with weight and shape

Current Physical Status:

Height (cm): _______________________ Weight (kg): _______________________ B.M.I.: ______

Weight Loss (   ) or Weight Gain (   ) of _______ kg over __________________________ (time period)

Date of last menstrual period: _______________________ BP: ________________ Pulse: ______

Has this patient ever received treatment for his/her eating disorder: Yes (   ) No (   )

If yes, please describe: _____________________________________________________________

________________________________________________________________________________

Do you feel this patient needs inpatient care?       Yes (   ) No (   )

Have you begun a referral to an inpatient program? Yes (   ) No (   )

If yes, to where: _________________________________________________________________

What is the anticipated admission date: _____________________________________________

Does this patient have any other known medical illness: Yes (   ) No (   )

If yes, please describe: ___________________________________________________________
Current Psychiatric Status:

Does the patient have any other known psychiatric concerns:  Yes ( ) No ( )

If yes, please describe: __________________________________________________________

________________________________________________________________________________

Has the patient had psychiatric consultation or treatment?  Yes ( ) No ( )

If yes, please indicate where and when: ______________________________________________

________________________________________________________________________________

Is the patient in current treatment with a mental health professional?  Yes ( ) No ( )

If yes, please name mental health professional: _______________________________________

Does this patient have (check all that apply):

( ) Current substance abuse   ( ) History of substance abuse   ( ) None

If yes, please describe (include substances abused and frequency): _______________________

________________________________________________________________________________

Does this patient have (check all that apply):

( ) Current self-injurious behaviour   ( ) Past self-injurious behaviour   ( ) None

If yes, please describe (include frequency): ___________________________________________

________________________________________________________________________________

Please include consultation notes and/or treatment summaries.

Medications:

Does the patient currently take any medications:  Yes ( ) No ( )

If yes, please list: __________________________________________________________________

________________________________________________________________________________

Please include with this any related consult/progress notes or other information that you feel relevant.

Thank you.