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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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		

- **THE FAMILY PHYSICIAN IS RESPONSIBLE FOR THE MEDICAL MONITORING OF THEIR PATIENT WHILE ATTENDING THE EATING DISORDERS PROGRAM -** Suggested Medical Monitoring Guidelines attached.

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

_____ HC#: _____ VC: _____
City, Postal Code

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: _____

_____

After our assessment you will be sent specific medical monitoring recommendations for your patient. In the meantime, please refer to the medical monitoring guidelines that were included with this referral form. If you did not receive these guidelines, please contact the program and ask for a copy to be faxed to you.

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.