Addendum to Centralized Intake Referral Form – Eating Disorders Unit

*__REFERRAL SOURCE__: The adolescent and parents must agree with the referral and sign below. Please review the checklist at the end of the referral and provide the necessary reports/documentation to support the referral.

PATIENT DEMOGRAPHIC INFORMATION

Legal patient name:	**Date of birth (M/D/Y):** **Age:**	**Gender:** ☐ Female ☐ Male ☐ Non-binary ☐ Transgender	**Grade:**

REFERRAL SOURCE INFORMATION

Referral facility:	**Name of person completing this referral:**	**Referral date (M/D/Y):**

CONSENT TO REFERRAL – TO BE COMPLETED BY THE PATIENT & PARENT(S)/CAREGIVER(S)

Patient:

☐ I consent to the referral to EDU for residential inpatient eating disorder treatment for myself

☐ I agree to attend Multi-Family Therapy in-person once/month with my parent(s)/caregiver(s) as part of my treatment

☐ I agree to participate in weekly individual and family therapy sessions

☐ I agree that my parent(s)/caregiver(s) will provide me with weekly (or more) in-person meal support

If offered a bed within 14 days, would you accept it?

☐ Yes ☐ No

Patient name (printed):

_____

Signature of patient:

_____

Parent(s)/caregiver(s):

☐ I consent to the referral to EDU for residential inpatient eating disorder treatment for my child

☐ I agree to participate in a family therapy workshop prior to admission

☐ I agree to attend Multi-Family Therapy in-person once/month with my child as part of their treatment

☐ I agree to participate in weekly family therapy sessions with my child

☐ I agree to participate in weekly (or more) in-person meal support with my child

If offered a bed within 14 days, would you accept it?

☐ Yes ☐ No

Parent(s)/caregiver(s) names (printed):

1. _____
2. _____

Signature(s) of parent(s)/caregiver(s):

1. _____
2. _____

GOALS OF ADMISSION

Goal #1:	
Goal #2:	
Goal #3:	

DIAGNOSTIC INFORMATION

Eating disorder diagnosis:	☐ Anorexia Nervosa Subtype: ☐ Restrictive ☐ Binge-purge ☐ Bulimia Nervosa ☐ Avoidant Restrictive Food Intake Disorder ☐ Other Specified Feeding or Eating Disorder ☐ Unspecified Feeding or Eating Disorder
	Age at diagnosis:
Other psychiatric diagnosis:	☐ Without comorbid psychiatric diagnosis
	☐ With comorbid psychiatric diagnosis

	Mood Disorder: Anxiety: Affect Regulation Disorder: Other/Please Specify:	
	Age of diagnosis:	
	Psychiatric symptoms:	
	Interventions to treat:	
Medical diagnosis:	☐ Without comorbid medical diagnosis	
	☐ With comorbid medical diagnoses Diagnosis: Age at diagnosis: Symptoms: Interventions to treat:	
Allergies:	☐ No known allergies	
	☐ Known allergies Diagnosis: Age at diagnosis: Symptoms: Interventions to treat allergies: *Food allergies: Medical documentation must be provided to support specific food allergies.	
MEDICAL INFORMATION		
Weight:	Current weight: _____ kg / _____ lb	Date weight recorded (M/D/Y):
	Estimated wellness weight: _____ kg / _____ lb	
	Current % of progress weight (formula: progress weight/current weight x 100): ☐ < 75% progress weight ☐ 75-85% progress weight ☐ > 85% progress weight	
Height:	Current height: _____ cm	Date height recorded (M/D/Y):
Menstrual function:	☐ Normal ☐ Primary amenorrhea ☐ Secondary amenorrhea (no vaginal bleeding >3 months)	
	Date of last menstrual period (M/D/Y):	
ECG: ***Must be completed within the past 4 weeks before the referral**	Date of most recent ECG (M/D/Y):	
	☐ Normal ☐ Bradycardia ☐ Other abnormalities	
	Please list abnormalities:	
Bloodwork: ***Must be completed within the past 4 weeks before the referral**	Date of last bloodwork (M/D/Y):	
	Labs requested: CBC and diff, electrolytes (calcium, magnesium, phosphate), glucose, urea, creatinine, AST, ALT, GGT, alkaline phosphatases, albumin, Vit b12, TSH, Ferritin	
	☐ Normal lab results ☐ Borderline lab results ☐ Abnormal lab results	
	Please list borderline or abnormal results:	
Heart rate:	Date information was obtained (m/d/y):	
	Lying: _____ beats/min Sitting: _____ beats/min Standing: _____ beats/min	

	☐ < 50 beats/min or orthostatic rise >10 ☐ 50-60 beats/min ☐ >60 beats/min
Blood pressure:	Date information was obtained (m/d/y):
	Lying: _____/_____ mm/hg Standing: _____/_____ mm/hg
	☐ < 80/50 or orthostatic drop > 20 ☐ Normal blood pressure for age
Oral temperature:	Celsius:
Medication:	**Current medication(s)**

Medication name	Dosage	Reason for starting	Date initiated (M/D/Y)

Past medication trials

Medication name	Dosage	Reason for stopping	Length of treatment

Vaccinations:	Please submit a copy of up to date vaccinations.

EATING DISORDER TREATMENT HISTORY – Attach additional history if needed

Inpatient eating disorder treatment:

Total number of inpatient eating disorder admissions: _____

☐ Currently admitted and planning to discharge home to outpatient or day treatment

☐ Currently admitted and unable to discharge home

Date of admission	Facility	Reason for admission	Degree of success	Duration

If currently admitted and unable to discharge home, describe why:

Outpatient eating disorder treatment:

Total number of outpatient treatment attempts: _____

☐ Currently in outpatient treatment

☐ Has received past outpatient treatment

☐ No adequate outpatient ED treatment completed due to lack of local availability

☐ No prior outpatient ED treatment completed although available – describe why:

Date of treatment	Facility	Services received (ie/ education, FBT, MFT, therapy, etc.)	Degree of success	Duration

Eating disorder day treatment:

Total number of day treatment attempts: _____

☐ Currently in day treatment

	☐ Completed day treatment in the past ☐ Attempted day treatment but unable to complete – describe why: ☐ No day treatment completed due to lack of local availability ☐ No day treatment completed although available – describe why:				
	Date of treatment	Facility	Services received	Degree of success	Duration

PSYCHIATRIC TREATMENT HISTORY NOT RELATED TO EATING DISORDER – Attach additional history if needed					
Inpatient psychiatric treatment (not related to eating disorder):	Total number of inpatient psychiatric admissions: _____ ☐ Currently admitted and planning to discharge home to other treatment (describe): ☐ Currently admitted and unable to discharge home				
	Date of admission	Facility	Reason for admission	Degree of success	Duration
Outpatient/day treatment psychiatric treatment:	Describe any outpatient or day treatment psychiatric treatment history below:				
	Date of treatment	Facility	Services received	Degree of success	Duration

EATING DISORDER SYMPTOMS & BEHAVIOURS **Mild = a few times per month; moderate = weekly to several times a week; severe = daily to multiple times a day**			
Symptom/behaviour list	**Past**	**Current**	**Severity of symptoms/behaviours**
Restriction	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Bingeing	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Purging	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Exercise	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Laxative use	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Ipecac use	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Temperature control	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Pica	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Rumination	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Chewing & spitting food	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Night eating	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Selective eating	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Other (please comment):	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe

CURRENT FEEDING NEEDS	
Current feeding needs:	Oral nutrition in food: ☐ 100% ☐ >50% ☐ 50% ☐ <50% ☐ 0%
	Oral nutrition in supplements (Ensure, 2Cal, etc.): ☐ 100% ☐ >50% ☐ 50% ☐ <50% ☐ 0%
	Nasogastric tube feeding (Ensure, 2Cal, etc.): ☐ 100% ☐ >50% ☐ 50% ☐ <50% ☐ 0%
	Does the patient require the use of any of the following to support current feeding needs: ☐ Medication ☐ Physical intervention from staff ☐ Mechanical restraints ☐ Chemical restraints Is there any aggression or violence toward self or others during feeding? ☐ Yes ☐ No Please describe:

BEHAVIOURAL SYMPTOMS – AGGRESSION, SELF-HARM, & SUICIDAL BEHAVIOURS Mild = a few times per month; moderate = weekly to several times a week; severe = daily to multiple times a day			
Symptoms/behaviour list	**Past**	**Current**	**Severity of symptoms/behaviours**
Aggression toward others	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
	Methods:		
	Context:		
Self-harm	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
	Methods:		
	Context:		
Suicidal plan – no intent	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
	Methods:		
	Context:		
Suicidal plan with intent	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
	Methods:		
	Context:		
Suicide attempt	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
	Methods:		
	Context:		
	# of attempts:		
FAMILY SUPPORT & COMMITMENT TO TREATMENT			
Living arrangements:	Patient lives with: Does patient have siblings? ☐ Yes ☐ No Describe: ☐ Other situation Describe:		
Legal custody arrangements:	Describe:		
Family/caregiver support:	Describe the patient and family/caregiver relationship and dynamics, including siblings:		
	Describe how the family/caregiver provides support to their child and any barriers or difficulties that impact care:		
	Please describe family/caregiver commitment to residential treatment and any barriers or difficulties that impact care:		
COMMITMENT FROM REFERRAL TEAM			
Follow up services:	☐ Referral source agrees to provide follow up services when patient is discharged from EDU		
Monthly updates and discharge planning sessions with the EDU team:	☐ Referral source agrees to participate in monthly/as needed updates and discharge planning session(s) with the patient and family prior to discharge from EDU		
Signature of referral source:	_____		

Develop a checklist for documents the referral source needs to include:

- □ Pertinent physician/psychiatric/specialist reports
- □ Pertinent therapist notes
- □ Consent forms for parents and teen – OS consents to be attached – Abby does this with the ADOL unit prior to admission
- □ ECG report

- □ Lab work
- □ Vaccinations
- □ Growth curves
- □ Copy of mental health act forms if applicable

Eligibility

- □ The patient must be between 12 and 17 years of age; the referral must be submitted at least four months prior to their 18th birthday
- □ All treatment options for eating disorders available in the patient's community have been unable to assist the adolescent to achieve recovery
- □ The adolescent is unlikely to benefit from a less intensive treatment other than residential care
- □ Serious eating disorder symptoms continue after less intensive treatments in the community have been undertaken. i.e. day treatment and outpatients if available in the community.
- □ Referring health care provider/agency is able to commit to provide appropriate follow-up after the teen has completed the Ontario Shores Eating Disorder program
- □ Referring health care provider/agency will take responsibility to provide or arrange an acute care bed should a patient become medically unstable and require transfer
- □ The patient must be medically stable. This is decided by the medical staff both at the referring site and at Ontario Shores. We rely on standard criteria to guide the decisions around medical stability.
  - Examples of criteria for medical instability:
    - <75% ideal body weight or ongoing weight loss despite intensive management
    - Heart rate < 50 beats per min daytime; <45 beats per min nighttime
    - Systolic pressure < 90 mm Hg
    - Orthostatic changes in pulse (>20 beats per min) or blood pressure (>10 mm Hg)
    - Hypothermia
    - Syncope
    - Hypokalemia
    - Hypoglycemia
    - Esophageal tears
    - Cardiac arrhythmias including prolonged QTC
    - Hematemesis