Ontario Shores
Centre for Mental Health Sciences

Addendum to Centralized Intake Referral Form for EDU
(To be completed for referrals requesting Eating Disorder Services)

Patient Name: _____ Gender: ❑Female ❑Male

Referral Source: _____ Referral Date: _____

Patient Age_____years Grade: _____	☐Grade 5-8 ☐<11 years ☐Grade 9-12 ☐ >18 years	
Diagnosis (please check): ☐ Anorexia Nervosa ☐ Bulimia Nervosa ☐ Binge Eating Disorder ☐ Pica ☐ Rumination Disorder ☐ Avoidant/Restrictive food intake disorder ☐ Other specified feeding or eating disorder Unspecified feeding or eating disorder	☐*without* another psychiatric diagnoses	
	☐comorbid psychiatric diagnoses	Please list co-morbid Psychiatric Diagnoses:
	☐ comorbid psychiatric symptoms	Please list co-morbid Psychiatric Symptoms:
	☐comorbid medical diagnoses	Please list co-morbid Medical Diagnoses:
Family support	☐Strong Family support ☐Some Family support ☐No family support ☐Other	Please describe family support/commitment to treatment and/or any barriers or difficulties that impact care:
Family commitment to residential treatment	☐Family strongly committed ☐Family ambivalent ☐Family Uncommitted ☐Other	Please describe family support/commitment to residential care and/or any barriers or difficulties that impact care::

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Prior hospital admissions

☐more than 1 admission
☐1 admission
☐ previous admissions

Please list *all previous inpatient ED admissions* : (continue on back if more room needed)

Date	Facility	Reasons	Duration

☐Currently admitted and unable to discharge

Please include:

Date of admission	Facility admitted to	Reasons for admission	Duration	*Reason* unable to discharge

Prior outpatient treatment

☐Completed psycho education
☐Completed family therapy

☐No adequate standardized Mental Health treatment completed due to lack of local availability

☐No prior standardized Mental Health treatment although available

Please list all previous outpatient ED treatments and include: *when*, *where*, and *duration*:

Date	Facility	Duration

If patient has not had outpatient family therapy treatment, please describe reason:

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<table>
<tr>
<td>Prior day treatment</td>
<td>☐Completed day treatment
☐ N/A
☐Attempted day treatment but unable to complete

☐No prior day treatment program completed due to lack of local availability

☐No prior day treatment program completed although available</td>
<td>Please list any previous course of ED day treatment, include w<u>hen</u>, <u>where</u>, <u>duration and outcome</u>:
<table>
<tr><th>Date</th><th>Facility</th><th>Duration</th><th>Outcome</th></tr>
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</table>
If patient has not had a course of day treatment, please describe reason:</td>
</tr>
<tr>
<td>Eating disorder behavior</td>
<td>☐Restriction (present or past)
☐Purging (present or past)
☐Laxative use (present or past)
☐Ipecac use (present or past)
☐No weight control
☐Pica
☐Rumination
☐Chewing & spitting food
☐Night eating
☐Selective eating
☐Other</td>
<td>Please describe eating disorder current behaviours (e.g., restriction, bingeing, purging, etc. Include frequency, severity and duration descriptors):</td>
</tr>
<tr>
<td>Suicidal or self-harm Behaviour</td>
<td>☐Suicide attempt (present or past)
☐Intent/Plan (present or past)
☐Suicidal gesture (present or past)
☐Self-harm behavior (present or past)
☐No self-harm</td>
<td>Please describe any current or past co morbid suicidal or self-harm ideation or behaviours (e.g. When, where, how):</td>
</tr>
</table>

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Menstrual Function	☐Normal ☐(Primary Amenorrhea: ☐ Secondary Amenorrhea (No vaginal bleeding **>**3 months) ☐N/A	LMP: _____
Current weight _____kg **Progress Weight** _____kg **Current height** _____cm	Progress Weight ___% ☐<75% PW ☐75-85 % PW ☐> 85% PW	
Heart rate 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 ____ / ____ Lying ____ / ____ Standing ☐<80/50 or orthostatic drop > 20 ☐Normal blood pressure for age		
Oral temperature _____° Celsius ☐<36 ☐36-36.2 ☐36.3 or> and afebrile		
EKG	☐Bradycardia ☐Other abnormalities ☐Normal ECG	Please list any abnormalities on the EKG:
Blood Work	☐Abnormal ☐Borderline ☐Normal lab work	Please list abnormal or borderline blood work results: