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):**

COMMITMENT FROM REFERRAL TEAM

Follow up services:	☐ **Referral source agrees to provide follow up services within 7 days of 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 /family prior to discharge from EDU
Signature of referral source:	_____
Signature of referral Physician	

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 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 a full day (Saturday) Multi-Family Therapy in-person once/month with my child as part of their treatment

☐ I agree to participate in weekly (or more) 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 and MEDICATION INFORMATION

<table>
<tr><td>Eating disorder diagnosis:</td><td>□ Anorexia Nervosa
Subtype: □ Restrictive □ Binge-purge
□ Bulimia Nervosa
□ Avoidant Restrictive Food Intake Disorder
□ Other Specified Feeding or Eating Disorder
□ Unspecified Feeding or Eating Disorder</td></tr>
<tr><td></td><td>Age at diagnosis:</td></tr>
<tr><td>Other psychiatric diagnosis:</td><td>☐ Without comorbid psychiatric diagnosis</td></tr>
<tr><td></td><td>☐ With comorbid psychiatric diagnosis
Mood Disorder:
Anxiety:
Affect Regulation Disorder:
Other/Please specify including SH □ SI □ Safety concerns□</td></tr>
<tr><td></td><td>Age of diagnosis:</td></tr>
<tr><td></td><td>Psychiatric symptoms:</td></tr>
<tr><td></td><td>Interventions to treat:</td></tr>
<tr><td>Medical diagnosis:</td><td>☐ Without comorbid medical diagnosis</td></tr>
<tr><td></td><td>☐ With comorbid medical diagnoses
Diagnosis:
Age at diagnosis:
Symptoms:
Interventions to treat:</td></tr>
<tr><td>Medication:</td><td>Current medication(s)
<table>
<tr><td>Medication name</td><td>Dosage</td><td>Reason for starting</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="3">Past medication trials</td></tr>
<tr><td>Medication name</td><td>Dosage</td><td>Reason for stopping</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
</table></td></tr>
<tr><td>Allergies:</td><td>☐ No known allergies</td></tr>
<tr><td></td><td>☐ Known allergies
Symptoms:
*Food allergies: Medical documentation must be provided to support specific food allergies.</td></tr>
<tr><td colspan="2">WEIGHT AND CURRENT FEEDING NEEDS</td></tr>
<tr><td>Weight:</td><td>Current weight: _____ kg / _____ lb</td><td>Date weight recorded (M/D/Y):</td></tr>
<tr><td></td><td colspan="2">Estimated wellness weight: _____ kg / _____ lb</td></tr>
<tr><td></td><td colspan="2">Current % of progress weight (formula: progress weight/current weight x 100):
☐ < 75% progress weight ☐ 75-85% progress weight ☐ > 85% progress weight</td></tr>
<tr><td>Current feeding needs:</td><td colspan="2">Oral nutrition in food: □ 100% □ >50% □ 50% □ <50% □ 0%</td></tr>
<tr><td></td><td colspan="2">Oral nutrition in supplements (Ensure, 2Cal, etc.): □ 100% □ >50% □ 50% □ <50% □ 0%</td></tr>
<tr><td></td><td colspan="2">Nasogastric tube feeding (Ensure, 2Cal, etc.): □ 100% □ >50% □ 50% □ <50% □ 0%</td></tr>
<tr><td></td><td colspan="2">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:</td></tr>
</table>

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 ; please explain why

Date of admission	Facility	Reason for admission	Degree of success	Duration

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

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

Referral acceptance will include a two-part assessment. The initial stage will include members of the Ontario Shores EDU team reviewing the referral. Should the referral meet initial criteria, the patient will participate in the second stage which will include an out patient assessment conducted by an Ontario Shores Psychiatrist via OTN. At that time, a decision will be made re referral acceptance.

Referral criteria:

- The client must be between 12 years of age 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 client's community have been unable to assist the adolescent achieve recovery.
- The Adolescent is unlikely to benefit from less intensive treatment other than an inpatient admission to Ontario Shores.
- Serious eating disorder symptoms continue after less intensive treatments in the community have been undertaken. i.e. day treatment/ 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 team will sign a repatriation agreement that is attached to the referral.
- Is actively engaged in treatment; treatment is uninterrupted until admission.

Referral exclusion criteria:

- Patient has not signed the agreement to referral
- Patients without a clear commitment to treatment
- Active SH
- Active SI
- SI/SH psych admissions within the last 3 months.
- Referral sources not agreeing to provide follow up services within 7 days of discharge from Ontario Shores. Please see Discharge Service Agreement attached and send with the referral.
- If the referral is incomplete within 30 days of receipt, the referral will close.

Admission criteria:

- > 80 % weight restored. Each case will be reviewed by the receiving physician prior to admission.
- Consuming all nutrition orally- preferably all food but agreeable to supplement (ensure) if meal is not consumed. Ready and willing to participate in active meal support at a table with peer group and EDU staff.
- No NG within past month or active plan for NG within the past month.
- Voluntary, Capable and motivated to be admitted to the program. Not to be Involuntary or Incapable; this is an elective admission from the community or a hospital.
- Minimal self-harm; no active suicidal ideation for the past month
- Discharge follow up agreement received

An Ontario Shores physician will contact the referring physician 24-48 hours prior to admission to ensure:

- Is medically cleared
- > 80 % weight restored. Each case will be reviewed by the receiving physician prior to admission.

Physiological:

- Heart rate >50 bpm at daytime, >45 bpm at night
- Orthostatic increase not higher than: 35 HR and >20 mm hg systolic and > 10 mm hg
- diastolic BP - : > 90/45 mmHg
- Body temperature > 35.6C
- No electrolyte disturbance-(hypokalemia, Hypoglycemia , hyponatremia , hypophosphatemia)
- No abnormalities in ECG (ECG within last 2 weeks)
- No acute medical complications: syncope, seizures, cardiac failure, renal failure,
- No dehydration
- Pregnancy
- Esophageal tears
- Cardiac arrhythmias including prolonged QTC
- Hematemesis
- Documents re 7 days prior admission_____(initials)

Referral Source Service Agreement (required)

The Ontario Shores Eating Disorder Unit will work collaboratively with the referral source. Prior to referral acceptance and admission to Ontario Shores, we request an agreement for follow up services with your team within 7 days of discharge from Ontario Shores and/or repatriation for medical instability/NG dependency.

The following measures will be put into place to support a successful discharge for the patient and their family.

- With consent from the client and their parent/ legal guardian name, telephone and/or OTN /zoom consultation with the referring team and Ontario Shores will occur throughout the admission to provide updates. These meetings will include recommendations for discharge planning and will support the discharge to your service within 7 days to ensure patient's success.
- Provide the patient, parent/legal guardian and the receiving care team with education on specific symptom management strategies that have been successful with the patient while at Ontario Shores.

This letter serves as your understanding and agreement that _____ (name of patient) will be accepted back to your Eating Disorder Out Patient Program within 7 days of discharge from Ontario Shores.

Referring health care provider/agency will take responsibility to provide or arrange an acute care bed within 7 days of request should a patient become medically unstable or NG dependent. _____(please initial)

_____(Director)
Name & Title (print and signature)
_____(Hospital/referral source)

Date: _____
I have the authority to bind _____(Hospital name/referral source) as the delegated signing authority to govern and oversee the operation of this Agreement.

_____(Psychiatrist/Physician)
Name & Title (print and signature)
_____(Hospital /referral source)

Date: _____
I have the authority to bind _____ (Hospital name/referral source name) as the delegated signing authority to govern and oversee the operation of this Agreement.