Addendum to Centralized Intake Referral Form –
Adolescent Eating Disorders Unit INPATIENT (LIVE-IN)

***REFERRAL SOURCE**: The adolescent and parents **BOTH** 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 ☐ Other, Please specify: _____	**Grade:**

REFERRAL SOURCE INFORMATION

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

COMMITMENT FROM REFERRAL TEAM

Follow up services:	☐ **Referral source agrees to provide appropriate follow up services within 7 days of when patient is discharged from EDU.**
Regular updates and discharge planning sessions with the EDU:	☐ Referral source agrees to participate in monthly/as needed updates and assist in discharge planning session(s) with the patient /family and EDU team prior to discharge from EDU
Name & Signature of referral source/program:	_____
Name & Signature of referring Physician/ NP	

CONSENT TO REFERRAL –
TO BE COMPLETED BY BOTH 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 participate in all individual, group and family therapy sessions

☐ I agree to attend Multi-Family Therapy in-person monthly with my parent(s)/caregiver(s)

☐ I agree that my parent(s)/caregiver(s) will participate with me in regular 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 regularly in family therapy sessions with my child

☐ 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 (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):

_____

_____

Parent(s)/caregiver(s) signatures:

_____

_____

Best phone numbers to reach parent(s)/caregivers(s):

_____

Parent(s)/ caregiver(s) emails:

_____

_____

GOALS OF ADMISSION	
Goal #1:	
Goal #2:	
Goal #3:	

DIAGNOSTIC and MEDICATION INFORMATION	
Eating disorder diagnoses:	☐ Anorexia Nervosa; Subtype: ☐ Restrictive eating ☐ Binge-purge ☐ Bulimia Nervosa ☐ Avoidant Restrictive Food Intake Disorder (ARFID) ☐ Other Specified Feeding or Eating Disorder:
	Age of first symptoms:
Other psychiatric diagnoses:	☐ No comorbid psychiatric diagnoses
	☐ With comorbid psychiatric diagnoses Mood Disorder: Anxiety Disorder: OCD/OCPD: Affect Regulation Disorder: Borderline Personality Disorder or Traits: Other (pls specify):
	Interventions to being utilized to treat these co-morbid conditions —Pls submit on separate document with referral
Medical diagnoses:	☐ No history of medical diagnoses/problems
	☐ History of medical diagnoses—Please specify and include more details on separate document with referral Diagnoses: Responsible Physician (PCP/Specialist) and contact information:

Medication:

Current medication(s)

Medication name	Dosage	Reason for starting

Past medication trial(s)

Medication name	Dosage	Reason for stopping

Allergies:	☐ No known allergies
	☐ Known allergies & symptoms: *Food allergies: Medical documentation must be provided to support specific food allergies.

WEIGHT AND CURRENT FEEDING NEEDS		
Weight:	Current weight: _____ kg / _____lb Current **Height**:	Date weight & height recorded (M/D/Y):
	Estimated wellness weight as determined by the treatment team: _____ kg / _____ lb Method for determining target weight:	
	Current % of wellness weight (formula: current weight/wellness weight x 100): ☐ < 75% wellness weight ☐ 75-85% wellness weight ☐ > 85% wellness weight	
	Serial Weights, Heights and Growth chart to be submitted in separate document with referral	

Current feeding needs:	Oral nutrition in food (percentage of recommended): ☐ 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%
	We do not accept patients who require: Mechanical restraints and/or Chemical restraints or any aggression or significant violence toward self or others during feeding

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

RESIDENTIAL eating disorder treatment:					

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 or lengthy waitlist

☐ No day treatment completed although available – describe why:

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

PSYCHIATRIC TREATMENT NOT LISTED ABOVE – Attach additional history if needed

INPATIENT PSYCHIATRIC treatment:

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

PSYCHIATRIC OUTPATIENT/day treatment and/ or other 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 & time frame	Current	Severity of symptoms/behaviours
Restriction	☐ Yes ☐ No	☐ Yes ☐ No; Describe:	☐ Mild ☐ Moderate ☐ Severe
Bingeing	☐ Yes ☐ No	☐ Yes ☐ No; Describe:	☐ Mild ☐ Moderate ☐ Severe
Purging	☐ Yes ☐ No	☐ Yes ☐ No; Describe:	☐ Mild ☐ Moderate ☐ Severe
Excessive Exercise	☐ Yes ☐ No	☐ Yes ☐ No; Describe:	☐ Mild ☐ Moderate ☐ Severe
Laxative use	☐ Yes ☐ No	☐ Yes ☐ No; Describe:	☐ Mild ☐ Moderate ☐ Severe
Vital Sign abnormalities	☐ Yes ☐ No	☐ Yes ☐ No; Describe:	☐ Mild ☐ Moderate ☐ Severe
Swallowing Difficulties, GERD or Rumination	☐ Yes ☐ No	☐ Yes ☐ No; Describe:	☐ Mild ☐ Moderate ☐ Severe
Meal Behaviours (Arranging, Hiding, Smearing, Spilling, spitting, etc.)	☐ Yes ☐ No	☐ Yes ☐ No; Describe:	☐ Mild ☐ Moderate ☐ Severe
Refeeding Syndrome	☐ Yes ☐ No	☐ Yes ☐ No; Describe:	☐ Mild ☐ Moderate ☐ Severe
Other (please comment):	☐ Yes ☐ No	☐ Yes ☐ No; Describe:	☐ 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	Current:	Time Frame (if in past):	Severity of symptoms/behaviours
Aggression toward others	☐ Yes ☐ No		☐ Mild ☐ Moderate ☐ Severe
	Describe:		
	Context:		
Self-harm	☐ Yes ☐ No		☐ Mild ☐ Moderate ☐ Severe
	Describe:		
	Context:		
Suicidal Ideation & plan – with no intent	☐ Yes ☐ No		☐ Mild ☐ Moderate ☐ Severe
	Describe:		
	Context:		
Suicidal plan with intent	☐ Yes ☐ No		☐ Mild ☐ Moderate ☐ Severe
	Describe:		
	Context:		

Suicide attempt	☐ Yes ☐ No		☐ Mild ☐ Moderate ☐ Severe
	Number of Attempts & Dates:		
	Describe:		
	Context:		
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/ friend(s) support:	Describe the patient and family/caregiver/friend relationships and dynamics, including siblings:		
	Describe how the family/caregiver/friends provides support to the teen and any barriers or difficulties that impact care:		
	Please describe family/caregiver commitment to inpatient treatment and any barriers or difficulties that impact care:		
MEDICAL INFORMATION —Please submit any laboratory and/ or specialist reports with referral			
Pregnancy:	Any possibility of pregnancy?	OBCP?:	
Menstrual function:	☐ Normal & regular	☐ Primary amenorrhea ☐ Secondary amenorrhea	
	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 ☐ QTc: ☐ Other abnormalities		
	Please list abnormalities:		
Bloodwork: ***Must be completed within the past 4 weeks before the referral**	Date of last bloodwork (M/D/Y):		
	PLEASE ATTACH COPY OF LABS RESULTS: Labs requested: CBC and diff, electrolytes (including calcium, magnesium, phosphate), glucose, urea, creatinine, AST, ALT, GGT, alkaline phosphatases, albumin, Vit b12, TSH, Ferritin		
	☐ Normal lab results ☐ Abnormal lab results		
	Please list borderline or abnormal results:		
Any History of Refeeding Syndrome	Please describe:		
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, including **COVID**		

REFERRAL CRITERIA AND PROCESS

Referral Acceptance will include a Three-part Assessment:

1. Initial Screening: Once all the information is received, the Ontario Shores Eating Disorder Unit (EDU) team will review the referral to ensure that it is complete and the patient meets the admission criteria below.
2. Second Stage: Should the referral be complete and meet initial criteria; the adolescent and parent(s) will participate in an outpatient interview by one of the Ontario Shores Psychiatrists via OTN. If further information obtained in this interview requires clarification, the psychiatrist will contact the referral source. At that time, a decision will be made regarding tentative acceptance or denial.
3. Third stage: Once tentatively accepted, the patient will be admitted to the EDU program for an assessment period of 1 to 3 weeks. The adolescent patient and parents who participate appropriately and continue to meet the criteria thru this assessment period will be fully accepted for the remainder of the EDU program.

At Ontario Shores we are aware that Eating Disorders are serious illnesses that have a high morbidity and mortality that require specialized care. Our Inpatient residential and day treatment programs are designed to treat adolescents with Anorexia Nervosa, Bulimia Nervosa and related conditions. We also recognize that we must also be able to treat some common co-morbid or related problems that often co-occur or are exacerbated by the eating disorder such as Major Depression (MDD), Generalized (GAD) or Social Anxiety (SAD), Obsessive Compulsive Disorder/personality (OCD/OCPD), Post-Traumatic Stress Disorder (PTSD), Identity disturbances, and some Borderline Personality traits. However, we do not have the expertise or resources to treat patients with severe Borderline Personality Disorder, especially in the presence of serious self-harm behaviors, ongoing suicidal attempts/threats, aggressive/oppositional behaviors, self-sabotage, or boundary violations that constitute "Therapy Interfering Behaviors." When we assess there may be interference from factors such as these that we may either not be able to accept these youths (exclusion from admission), or if there are some doubts on whether the teen is truly motivated and willing to recover, we may decide to admit for a short assessment period before deciding if they are appropriate and able to benefit from our program. In these cases, we will be upfront with the patient and family about what will be expected for us to be able to hep them and continue with the admission.

In recognition of the recent increased incidence of Eating Disorders and the lack of available resources for these unfortunate teens and their families we have relaxed some of our admission criteria to include the adolescents who are suffering from serious Anorexia Nervosa or Bulimia Nervosa and not yet able to find adequate treatment. Hopefully this can prevent further deterioration before there is access to specialized treatment and prevent the need for medical admissions.

REFERRAL CRITERIA:

- The adolescent must be between 12 years of age and 17 years, 8 months of age. This means that the patient can only be admitted to the program at least four months prior to their 18th birthday because they cannot continue in the program after they turn 18.
- Referral must be made by a physician or Nurse Practitioner (e.g. Psychiatrist, Paediatrician, Primary Care Provider, etc). If the referral is initiated by a treatment program, therapist, patient or parent it still must be done in concert with a Physician or NP who will sign the referral form
- The adolescent and parent(s) must be willing to actively and appropriately engage in treatment.
- If the patient and family are actively engaged in treatment, this treatment must continue until admission.
- Referring health care provider, agency and Primary Care Provider are able to commit to provide appropriate follow-up after the adolescent has completed or discharged from the Ontario Shores EDU program. If a higher level of care is needed at discharge than the referral source provides, they should assist us in finding those resources
- Referring team will sign the appropriate **collaborative service agreement** that is attached to this referral.

Please note:

- If this referral is coming from a **Acute Care Medical facility,** Please complete the Collaborate Service Agreement for Referrals from Acute Care Medical facilities
- If this referral is coming from a **Psychiatric acute care setting,** Please complete the Collaborative Service Agreement for Referrals from Acute Care Medical facilities
- If this referral is coming from an **outpatient setting** (e.g., outpatient program), please complete the Collaborative Service Agreement for Referrals from an Outpatient Treatment
- If this referral is coming from a **primary care provider or Community Psychiatrist** (e.g., NP or Physician), please complete the Collaborative Service Agreement for referrals from a Primary Care Provider/ Community Psychiatrist/ Nurse Practitioner

ADMISSION CRITERIA:

- At least 75 % of estimated wellness weight and routinely meeting medical stability requirements (see below). Each case will be reviewed by the receiving physicians prior to admission
- Taking in an adequate amount of nutrition orally (supplement and solid food), willing to increase consumption to return to full health, and ready and willing to participate in active meal support at a table with peer group and EDU staff
- Patient and parents are agreeable to following the appropriate meal plan and not resistant (no recent attempts to pull out NG) to placement and use of an NG tube for re-feeding if unable to take in adequate nutrition orally.
- Voluntary, Capable and motivated to be admitted to the program. If patient is involuntary or incapable, both patient and parents must understand that if the patient is resistant to treatment when they become capable, this may limit our ability to effectively continue treatment and may result in a premature discharge.
- The patient must be able to appropriately participate in all aspects of the EDU program. Therefore, they should be able to communicate adequately, and be developmentally and cognitively capable of appropriate participation in order to benefit from our program
- Minimal self-harm; not actively and seriously suicidal.
- Discharge follow up agreement received

MEDICAL CRITERIA:

Must consistently meet the Criteria below

- At least 75 % weight restored at time of referral and admission to Day Treatment
- Consistently meeting medical stability requirements (see below). Each case will be reviewed by the receiving physicians prior to admission
- Patients must have a heart rate >45 bpm during the daytime and >40 at nighttime
- Orthostatic heart rate change must be <35 bpm and asymptomatic (no recent syncopal episodes)
- Blood Pressure must be >80/50 and orthostatic drop is <20
- In some cases (e.g. high level athletes) may be exempted from these VS criteria if there is proof of baseline bradycardia/hypotension prior to onset of eating disorder
- Body temperature > 35.6C
- No significant Electrolyte disturbance currently -(hypokalemia, hypoglycemia, hyponatremia, hypophosphatemia)
- No current acute medical complications: syncope, seizures, cardiac failure, renal failure, severe gastro-intestinal distress, severe deconditioning, etc.
- No significant abnormalities in ECG (ECG within last 2 weeks) No Cardiac arrhythmias including prolonged QTc
- If cardiac abnormalities are/were present they must have resolved or we will need Cardiologist clearance to continue recent medications and for safety to attend program
- No hematemesis. No esophageal tears
- Not pregnant
- Medical documentation must be up to date 7 days prior admission_____(initials)

REFERRAL EXCLUSION CRITERIA:

- Adolescent and/or family has not signed the referral agreement (unless incapable due to refusal to come despite clear and unambiguous support from family for admission and treatment)
- Adolescent and/or family are not clearly committed to treatment, disagree on treatment goals set by the program, or not wanting or not able to consistently attend program
- Engagement in self harm that is treatment interfering (e.g., self harming in front of other patients, self harm requiring any medical or physical intervention etc.)
- Active suicidal ideation with a plan and/or intent, or recent hospitalization for such
- Referral sources not agreeing to provide appropriate follow up services, when required, within an agreed upon timeframe of discharge from Ontario Shores. Please see Discharge Service Agreement attached, sign and send with the referral
- Those diagnosed with Binge eating disorder alone
- Significant and severe borderline personality symptoms
- Not able to consume adequate nutrition orally (minimum of 50% in solid food, remainder in nutrition supplements)
- Not ready and/or willing to participate in active meal and snack support at a table with peer group and EDU staff
- Requires enteral feeding (NG tube, G-tube etc.)
- Program may not be helpful for those who are not cognitively able to participate in their care and adequately participate in the treatment program
- **Patient not medically stable**

EVALUATION & TRIAL ADMISSION PERIOD

- May be required of some patients and family if it is unclear if they fully meet admission criteria

GROUNDS FOR EARLY DISCHARGE

- Patient and/or parent(s) are unwilling and/or unable to follow our proposed treatment plan such that we will not be able to successfully help the adolescent make significant progress.
- Lack of consistent and appropriate patient engagement and participation
- Lack of consistent and appropriate parent engagement and participation
- Patient is not able to consistently keep self safe or the patient endangers staff or other patients
- Not able to cooperate with nutrition plan including, but not limited to, taking in sufficient nutrition by mouth or needing more than short NG tube feeding
- Not able to consistently follow the rules and requirements of the unit and program
- Needs of co-morbid disorder exceed the capacity of the EDU program to safely and effectively manage and treat the Eating Disorder or cause significant interference with Eating Disorder treatment

Ontario Shores
Centre for Mental Health Sciences

Collaborative Service Agreement for Referrals from Acute Medical Facilities

You and your facility agree to work collaboratively with Ontario Shores to:

- Repatriate patient to your facility if the patient becomes medically unstable/ NG dependent as Ontario Shores is not an acute care facility and cannot provide this level of care.

- Obtain follow up services from your organization when required. We are requesting that the follow up with your team occur within 7 days of discharge.

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, 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.

- Provide the patient, parent/legal guardian and the receiving care team with an update on psychiatric and medical interventions, progress made during the inpatient residential stay, issues that will need to be addressed post-discharge from EDU, and education on specific symptom management strategies that have been successful with the patient while at Ontario Shores. Please provide name, phone, and email contact for your care coordinator.

  _____

This letter serves as your understanding and agreement that:

- The patient will be accepted back to your Eating Disorder Out Patient Program within 7 days of discharge from Ontario Shores.

- Your organization will work collaboratively with Ontario Shores to arrange an acute care medical bed 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/ NP)

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.

Ontario Shores
Centre for Mental Health Sciences

Collaborative Service Agreement for Referrals from an Outpatient Treatment Service

You and your organization agree to work collaboratively with Ontario Shores to:

- Obtain follow up services from your organization when required. We are requesting that the follow up with your team occur within 7 days of discharge.

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, 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.

- Provide the patient, parent/legal guardian and the receiving care team with an update on psychiatric and medical interventions, progress made during the inpatient residential stay, issues that will need to be addressed post-discharge from EDU, and education on specific symptom management strategies that have been successful with the patient while at Ontario Shores. Please provide name, phone, and email contact for your care coordinator.

  _____

This letter serves as your understanding and agreement that:

- The patient will be accepted back to your Eating Disorder Out Patient Program within 7 days of discharge from Ontario Shores.

_____(Director)
Name & Title (print and signature)
_____(Organization/referral source) Date: _____

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

Ontario Shores
Centre for Mental Health Sciences

Collaborative Service Agreement for Referrals from a Primary Care Provider/ Community Psychiatrist/ Nurse Practitioner

You and your organization agree to work collaboratively with Ontario Shores to:

- Continue following the patient and arrange a follow up appointment within 7 days of discharge.

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, 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.

- Provide the patient, parent/legal guardian and the receiving care team with an update on psychiatric and medical interventions, progress made during the inpatient residential stay, issues that will need to be addressed post-discharge from EDU, and education on specific symptom management strategies that have been successful with the patient while at Ontario Shores. Please provide name, phone, and email contact for your care coordinator.

  _____

This letter serves as your understanding and agreement that:

- The patient will be accepted back to your Eating Disorder Out Patient Program within 7 days of discharge from Ontario Shores.

_____(Director)
Name & Title (Primary care provider/ community psychiatrist/ nurse practitioner)

Signature: _____ Date: _____