PEDIATRIC EATING DISORDERS PROGRAM
HAMILTON HEALTH SCIENCES

Today's Date: _____ Health Care # _____

Patient's Name: _____ DOB _____
D/ M/ Y/

Address: _____ Postal Code: _____

Parent's Names: _____

Phone # (Res): _____ (Bus) _____

(Cell) _____

Referral Source: _____ Phone #: _____

Backline #_____

Address: _____

Referring MD Name:_____ Ref MD Billing # _____

Name of Primary Care Physician: _____

Is the family aware of the referral? Y ( ) N ( )

Additional comments:

WEIGHT: Present _____ kg Date: _____

HEIGHT: Present _____ cm Date: _____

MAXIMUM KNOWN WEIGHT _____ Date _____

WEIGHT HISTORY:

Please provide any known past weights and heights from birth.

WEIGHT CONTROL METHODS:

	Y/N	Describe Frequency/ Type
FOOD RESTRICTION		
BINGEING		**□ Monthly □ Weekly □ Daily** **□ More than 1 x per day**
VOMITING		**□ In the past but not currently** **□ Monthly □ Weekly □ Daily** **□ More than 1 x per day**
LAXATIVES		**□ Type** **□ Frequency**
EXERCISE		**□ No formal activity □ 30 – 60 minutes per day** **□ Competitive athlete**

MENSES:

Menarache	
Last Menstrual Period	
Primary Amenorrhea	
Secondary Amenorrhea	

MEDICAL STABILITY:

Blood Pressure	**Lying:**	**Standing:**	**Date:**
Heart Rate in office **ECG Required for all referrals ***	**Lying:**	**Standing:**	**Date:**
Oral Temperature			**Date**

MEDICATIONS

Prescribed	**Name:**	**Dose (s)**	
Non-Prescribed	**Name:**		

MENTAL HEALTH HISTORY

	Depression	
	Anxiety Disorder	
	OCD	
	Personality Disorder	
	Substance Abuse	□ Alcohol □ Other
	Suicidal Ideation or Intent	□Past □ Active
	Suicidal Behaviour	□Past □ Active
	Self Harm Behaviour (s)	□Past □ Active
	Psychiatric Assessment/ Treatment	□Past □ Active □ Attach Consultation Note □ Prior Admissions
	Eating Disorder	□ Past Admissions □ Attach relevant consultations

This program treats primary Eating Disorders. It is highly recommended that you also refer to your local Children's Mental Health program or Psychiatry option in your community if you feel that your patient has significant co-morbid mental health issues.

BLOODWORK AND INVESTIGATIONS

Complete blood work and ECG are required before an appointment can be booked with this clinic.

Hematology

x	CBC	x	SED Rate (E.S.R.) or c-reactive protein (CRP)

Chemistry

x	Lytes (Na, K, Cl)	x	P04 (Phosphate)
x	K (Potassium)	x	Urea
x	Glucose (Random)	x	MG (Magnesium)
x	CR Creatinine	x	CA (Calcium)

Cardiac

ECG Required Please fax print out	**Date Ordered:**

ADDITIONAL REFERRALS:

No ( ) I am only referring my patient to McMaster at this time
Yes ( ) I have also referred to :

Child and Youth Mental Health Program	**□ Hamilton** **□ Other**	

PLEASE RETURN COMPLETED FORM BY FAX TO:

The Pediatric Eating Disorders Program
McMaster Children's Hospital, 3F Clinic
ATTN: Cheryl Webb, Clinical Coordinator

If you feel that your referral is URGENT, please fax intake form and then call directly OR page Adolescent Medicine on call at 905 521 5030.

Phone: (905) 521-2100, x73497 Fax: (905) 521 2349