McMaster Children's Hospital

Pediatric Outpatient Eating Disorders Program Referral Form

Physician/Nurse Practitioner Referral Only

Referral Date:

INCLUSION CRITERIA (Referrals from outside the region will not be processed)

- Primary Diagnosis of an Eating Disorder
- Under 17 years of age at the time of the referral
- Within region of Hamilton/Burlington/Brantford/Niagara/ Haldimand-Norfolk
- Moderate to severe symptoms

  a)Significant and/or rapid weight loss

  b)Frequent binge or purge symptoms
- Not looking for weight loss program
- ARFID:

  At least 7 years old AND one of:

  Growth failure

  Nutritional deficiency or

  Full dependence on nutritional supplements

  (NOTE weaning from G-tube feeds is not an area of expertise)

PHYSICIAN INFORMATION

Referring MD/NP: _____ Specialty: _____

Phone: _____ Fax:_____

Billing Number: _____

Primary Care Practitioner: _____

Phone: _____ Fax: _____

PATIENT INFORMATION

Last Name: _____ Legal First Name: _____

DOB: _____ Age: _____ Sex Assigned at Birth: _____

Affirmed/Chosen Name: _____ Pronouns Used: _____

Current Gender Identity: _____

Address: _____City: _____ Postal Code: _____

Health Card Number: _____ Version Code: _____

CAREGIVER INFORMATION

Parent/Caregiver Name: _____

Relationship to Child: _____

Home Phone: _____ Other Phone: _____

Email: _____

Is an interpreter required? ❑Yes ❑No If yes, which language? _____

Is the patient/family aware of this referral? ❑Yes ❑No

Is this referral confidential? ❑Yes ❑No *If yes, please contact Clinical Specialist at ext 73049*

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REQUIRED INFORMATION

Medical Stability

Present height (cm): _____ Present weight (kg): _____

Lowest weight and date: _____ Highest weight and date: _____

*** Please include any past weights or heights on file in your office.

Heart rate lying: _____ Heart rate standing: _____

Blood pressure lying: _____ Blood pressure standing: _____

Weight Control Methods

	Y/N	Describe Frequency/ Type
Food Restriction		
Bingeing		❑ **Daily** ❑ **Weekly** ❑ **Monthly** ❑ **More than 1x per day**
Vomiting		❑ **In the past but not currently** ❑ **Daily** ❑ **Weekly** ❑ **Monthly** ❑ **Misuse of insulin**
Laxatives		❑ **Type _____** ❑ **Frequency _____**
Exercise		❑ **30-60 minutes a _____** ❑ **Competitive Athlete**
ARFID		❑ **Extreme food selectivity** ❑ **Fear of vomiting** ❑ **Fear of choking** ❑ **Restricting intake for other reason (please specify)** **_____**

Age of Menarche (first period)	
Last Menstrual Period (date)	

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Y/N	Mental Health Concerns	Notes
	Depression	
	Anxiety Disorder	
	OCD	
	Personality Disorder	
	Substance Abuse	❑ **Substance** ❑ **Other**
	Suicidal Ideation or Intent	❑ **Past** ❑ **Active**
	Suicidal Behavior	❑ **Past** ❑ **Active**
	Self-Harm Behavior (s)	❑ **Past** ❑ **Active**
	Psychiatric Assessment/Treatment	❑ **Past** ❑ **Active** ❑ **Past Admissions** ❑ **Attach Consult Notes**
	Eating Disorder	❑ **Past Admissions** ❑ **Attach Consult Notes**

The McMaster Eating Disorders Program **DOES NOT** treat co-morbid mental health concerns. Please jointly refer your patient for general mental health concerns.

Is the patient currently receiving mental health services? ❑Yes ❑No Where: _____

Have you referred to a general mental health service? ❑Yes ❑No Where: _____

Required Attachments:

- Patient's growth curve or any past weights/heights including dates on file.
- A copy of the patient's most recent ECG, this is required for your patient's referral to be processed.
- Bloodwork listed on the following page must be completed and attached.

Hematology

x	CBC	x	

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)

Any recent admissions or ER visits? ❑Yes ❑No If yes, please attach the details of those visits.

Attach copies of all medical or related assessments

Attach copies of all mental health/family assessments.

Attach copy of Bone Mineral Density results if completed.

Please page the Adolescent Medicine Physician on call (905-521-5030) PRIOR TO SENDING HOME as an urgent assessment or local admission may be recommended if any of the following issues are present:

- Rapid acute significant weight loss
- Heart rate <50 beats per minute
- Acute Food Refusal with associated rapid weight loss or medical stability
- Hypotension for age
- Severe emaciation (<75% target weight)
- Hypothermia
- Cardiac Arrythmia or Prolonged QTc
- Glucose <3.0 mmol/L
- Phosphate <0.8 mmol/L
- Hematemesis
- Significant Dehydration
- K< 3.2 mmol/L
- Na < 135 mmol/L
- Calcium < 2.1 mmol/L

If the primary concern is around suicidality, the patient should be assessed by the local mental health/crisis team

We recommend regular monitoring by referring clinicians of physical and mental health status. If there are deteriorations in clinical status, please contact the physician on call for Adolescent Medicine.

You will receive a letter indicating the status of your patient's referral. Your patient will be contacted directly with their appointment.

Referring Provider Signature: _____

Please fax the completed referral form to 905-521-2330.
Note: Referral must be complete to be considered. Incomplete referrals will not be processed.

A digital version of this referral form is available on the McMaster Children's Hospital Website.