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: ______________________ Back Line:______________________

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 (kg): ____________ (dd/mm/yy):_____________

Highest weight (kg): ___________ (dd/mm/yy):_____________

Amount of weight lost (kg): _________________ Since (dd/mm/yy): ________________________

Heart rate lying: ______________ Blood pressure lying: _______________

Heart rate standing: ________________ Blood pressure standing: _________________

Date orthostatic vitals were completed: ___________________

Required Attachments

- ❑ Patient's growth curve or any past weights/heights including dates on file.
- ❑ Copy of ECG completed in the last 30 days, this is required for the referral to be processed.
- ❑ Copies of all medical/mental health/family assessments.
- ❑ Copy of Bone Mineral Density results if completed.
- ❑ Bloodwork listed below must be completed within the last 30 days and attached.

Hematology

x	CBC	x	ESR/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)

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

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
- Syncope as presenting symptom
- Severe emaciation (<75% target weight)
- Glucose <3.0 mmol/L
- Phosphate <0.8 mmol/L
- Significant Dehydration
- K< 3.2 mmol/L
- Hypothermia
- Hypotension (SBP <90 mmHg)

Weight Control Methods

	Y/N	Describe Frequency/ Type
Food Restriction		❑ **Daily** ❑ **Weekly** ❑ **Monthly** ❑ **More than 1x per day**
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		❑ **Frequency** _________________ ❑ **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)	

Mental Health

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: ___________________

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.

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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

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.