McMaster Children's Hospital
1200 Main Street West,
Hamilton, ON, L8N3Z5
905-521-2100, x 73289

Pediatric Eating Disorder Day Treatment Referral

PLEASE NOTE THAT INCOMPLETE REFERRALS WILL NOT BE PROCESSED

ADMISSION CRITERIA: (Please check)

☐Primary diagnosis of an eating disorder
☐At least 8 weeks of treatment by local ED treatment team who completed day treatment referral package
☐Medically stable and 75-80% of treatment goal weight ****See back for reasons to call Physcian**
☐Oral intake must be majority solid food
☐Commitment to attending for a minimum of 6 weeks and following all expectations outline in the contract (to be reviewed with a therapist as an outpatient)
☐Connected with, and actively receiving treatment, in an Eating Disorder program and willingness to return
☐Not actively suicidal
☐No aggressive or sexually inappropriate behaviour
☐Will eat nutrition, including replacement, provided by the program (those on a vegan diet cannot be accommodated)
☐Parents or guardians will be available for family meetings every two weeks and pick-ups from program if warranted (this could be in the middle of the day)
☐Parents or guardians can get patient to and from day treatment daily
☐Must be age 13 or older

DATE OF REFERRAL:

DD/MM/YR:

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Preferred Name: _____

DOB (day/mo/year): _____Age: _____ Gender: _____

Street: _____ City: _____ Postal Code: _____

Health Card # and version code: _____

Home Phone Number: _____

Contact Person: _____ Relationship: _____ Phone number: _____

PARENT/GUARDIAN INFORMATION

Name: _____ Relationship: _____ Phone #: _____ Legal guardian? Yes ☐ No ☐

Name: _____ Relationship: _____ Phone #: _____ Legal guardian? Yes ☐ No ☐

Interpreter required? If yes, language: _____

REFERRING PHYSICIAN/NURSE PRACTITIONER INFORMATION:

Last Name:_____ First Name: _____
Phone #: _____ Fax#: _____
Discipline (e.g. FMD, NP, Pediatrician, psychiatry): _____
Billing Number: _____

Family physician (if different from referring clinician): _____

CLINICAL INFORMATION

Date first evaluated by your ED Program: _____

Diagnosis ☐ AN ☐ BN ☐ OSFED ☐ ARFID ☐ Other _____
Comorbid Diagnosis ☐ GAD ☐ SAD ☐ Depression ☐ Other _____
Brief Reason for Referral _____
_____

****REQUIRED INFORMATION TO PROCESS REFERRAL****

Anticipated goals for day treatment: ☐ weight restoration ☐ normalize eating ☐ interrupt binge/purge behaviours
☐ Other (please list) _____

_____

History of ☐ Self Harm ☐ Suicidality Please provide details _____

_____

Team members involved:
☐ Psychiatry (name & contact #)_____ ☐ Consult attached
☐ Social Worker (name & contact #) _____
☐ Nurse Practitioner (name & contact #) _____ ☐ Registered Dietitian _____
☐ Private practitioner _____ ☐ Other _____

_____

Treatment approaches to date: ☐ FBT ☐ DBT ☐ CBT ☐ Other _____
☐ **CAS involvement** ☐ past or ☐ current (name & contact #) _____

Today's weight (kg): _____ Today's height (cm): _____
Lowest weight/date: _____
Highest weight/date: _____ Estimated Target Weight: _____
Please attach growth curve:☐ attached
Heart rate (lying and standing) _____ BP (lying and standing): _____
Medications:(including doses and duration of rx):

_____

_____

☐ Patient has declined use of medication

Recent admissions or ER visits? Y/N If yes, please attach details of those visits:☐
Attach copies of initial medical assessment including all blood work done:☐
Attach copies of all mental health/family assessments:☐
Attach copy of most recent EKG: ☐
If done, attach copy of Bone mineral density results:☐

Please page the Adolescent Medicine Staff on call (905-521-5030) <u>PRIOR TO SENDING HOME</u> if any of the following issues are present. Be aware that if any of the following issues are present the patient will not be a candidate for Day Treatment

☐ Rapid acute significant weight loss
☐ Heart rate < 50 beats per minute
☐ "Hunger strike" with associated rapid weight loss or medical instability
☐ Systolic BP <90 mm Hg
☐ Severe emaciation (< 75% target weight)
☐ K< 3.2 mmol/L
☐ Hypothermia
☐ Na < 135 mmol/L
☐ Glucose <3.0 mmol/L
☐ Calcium < 2.1 mmol/L
☐ Phosphate< 0.8 mmol/L
☐ Prolonged QTc
☐ Hematemesis
☐ Significant Dehydration

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

Depending on the above information, we may recommend that the patient be admitted locally (if no beds available at MUMC) or they may be put on our waiting list for assessment.

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.

☐ **I have reviewed the contract for Day Treatment with parents and child and both agree to the terms of the contract**

Please return completed referral by fax to: (905) 521-2330. Thank you for your referral

INTERNAL USE ONLY : ☐ Referral Accepted Date: ☐ Referral Declined Date: