Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

Hôpital Général de Kingston General Hospital

ADULT EATING DISORDERS PROGRAM REFERRAL FORM

PHONE: 613-544-3400 ext. 2506 | **FAX:** 613-545-1364

Patient Name: ____________________

Date of Birth (yyyy/mm/dd): ____________________

Health Card: ____________________ - ________

Address: ____________________

____

Telephone (Home/Mobile): ____________________

Date of Referral (yyyy/mm/dd): ____________________

NOTE: The Adult Eating Disorder Clinic at the Hotel Dieu site of the KHSC is an out-patient, group therapy based program that treats individuals with a Body Mass Index (BMI) of over 16 who meet DSM-5 diagnostic criteria for an eating disorder (with the exception of Binge Eating Disorder, which we do not currently treat). We do not offer intensive day hospital or inpatient treatment and we are unable to offer individual therapy.

CURRENT PHYSICAL STATUS		
Weight: ______________ **(kg)**	**Height:** ______________ **(cm)**	**BMI:** ______________

CURRENT SYMPTOM PRESENTATION	
SYMPTOM	**FREQUENCY**
☐ Restricting Food Intake	
☐ Binge Eating	
☐ Vomiting	
☐ Laxative Use	
☐ Diuretics	
☐ Diet Pills	
☐ Exercise	
Other Symptoms/Relevant Information:	

RISK FACTORS	YES	NO
Harm To Self		
Harm To Others		
Other Risk Factors (e.g. pregnancy, concurrent disorders, inability to care for self)		

PREVIOUS TREATMENT	YES	NO
Previous Eating Disorder Treatment?		
Previous Psychiatric Assessment?		
Previous Dietitian Involvement?		
If you answered yes to the above questions please include relevant documentation		

INVESTIGATIONS *(Blood work must be within the last 3 months)*	
☐ CBC and Diff., Ferritin, B12, Electrolytes, TSH, Glucose, random (not fasting) ☐ Electrocardiogram (ECG)	☐ Bone Mineral Density *(if ever amenorrheic for greater than three months)*

____

REFERRING PRACTITIONER (PRINT NAME) | DESIGNATION | SIGNATURE | DATE (yyyy/mm/dd)