Provincial Specialized Eating Disorders Programs

Referral Form

For patients up to 17 years of age:

BC Children's Hospital
Provincial Specialized
Eating Disorders Program
P3-212 / 4500 Oak Street
Vancouver, BC V6H 3N1
Tel: (604) 875-2010

Fax form to: (604) 875- 2099

For patients 17 years & older:

St. Paul's Hospital
Provincial Specialized
Eating Disorders Program
1081 Burrard Street
Vancouver, BC V6Z 1Y6
Tel: (604) 806-8347 ext. 4

Fax form to: (604) 806-8631

Important: Please ensure that your patient is referred or connected to a *regional program* in their area before a referral is made to these Specialized Programs.

Referring Professional:

Are you: ☐ GP/Family Doctor ☐ Pediatrician ☐ Psychologist ☐ Psychiatrist ☐ Regional Program ☐ Other (specify) _____

Are you the primary care provider? ☐ Yes ☐ No

MSP Billing # _____

Your name: _____ (last) _____ (first) _____ (middle initial)

Office phone #: ( ) Office Fax #: ( )

Address Street:

City: Postal Code:

Currrent psychological or psychiatric treatment:

✹Attach existing consultation reports if available

☐	Mental Health Team	☐ No	Location & #: _____
☐	Psychiatrist	☐ No	Name & #: _____
☐	Psychologist	☐ No	Name & #: _____
☐	EAP	☐ No	Name & #: _____
☐	Therapist/Counselor	☐ No	Name & #: _____

Patient information - Personal history

Patient's legal name (please print) ☐ Male ☐ Female ☐ Other _____

_____ **Last Name** _____ **First Name** _____ **Middle name**

BC PHN # (mandatory) _____ DOB: _____ / _____ / _____
Year Month Day

Non-BC medical # _____ Province: _____ Expiry date: _____

Primary language: ☐ English ☐ Other, describe: _____

Patient's current address:

Street: _____ Apt #_____ City: _____ Postal code: _____

Current Home #: ( ) Patient's Cell #: ( )

Work # if applicable: ( ) Other #: ( )

Eating disorder related information:

Current HT _____ in / cm Current WT _____ LBS / KG

Lowest WT _____ LBS / KG age or year: _____ Highest WT _____ LBS / KG Age or year: _____

Heart rate _____ _____ (Orthostatic) BP _____ _____ LMP _____

Eating disorder-related behaviours – please describe:

☐ Restriction ☐ Bingeing ☐ Vomiting ☐ Laxatives/diuretics use ☐ Over-exercising

Please describe frequency of above activities:

Medical History

☐ **Diabetes** ☐ **Pregnant** ☐ **Substance Use/Dependent**

Describe any other medical issues:

Lab work ✹ Mandatory: Please provide a copy of the following with this referral:

•CBC • Lytes (+glucose) •CA •MG •PO4 •Ferritin •CR •BUN •ESR •TSH

•ECG - Please send a copy with this form.

Psychiatric history

✹ Previous psychiatric consults or reports required

Please describe any psychiatric issues or previous admissions: