Provincial Specialized Eating Disorder Program
REFERRAL FORM

NSHA
For patients 19 years and older:
Abbie J. Lane Memorial Building−Eating Disorders Program
5909 Veterans' Memorial Lane
Halifax, NS B3H 2E2
Telephone: 902−473−6288
Fax: 902−473−6282

IWK
For patients 18 years and younger:
IWK Health Centre−Eating Disorders Specific Care Clinic
5850/5980 University Avenue
PO Box 9700, Halifax, NS B3K 6R8
Telephone: 902−470−8375
Fax: 902−470−7893

Allergies: _____

Date of Referral: _____ (YYYY−MM−DD)

Patient Name: _____ (First Middle Last) Date of Birth: _____ (YYYY−MM−DD)

Address: _____

Telephone Numbers Home: _____ Work: _____ Cell: _____

Child/Adolescent−Parents' Names: _____

Adults−Marital Status: _____ Employed: ❑ Yes ❑ No Occupation: _____

On Disability: ❑ Yes ❑ No General Psychiatric Assessment Completed: ❑ Yes ❑ No

Referring Physician: _____ Specialty: _____

Signature: _____ Date (YYYY−MM−DD): _____

Address: _____

Telephone Number: _____ Fax Number: _____

Reason for Referral/History of Presenting Concerns:

_____

_____

_____

Weight Control Methods:

	Yes	No	Frequency / day	Frequency / week
Food Restriction				
Binge Eating				
Vomiting				
Laxatives				

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Diuretics				
Ipecac				
Diet Pills				
Cocaine/Amphetamines				
Excessive Exercise				

Menses:

Regular Cycles: ❑ Yes ❑ No Age at Menarche: _____ On BCP: ❑ Yes ❑ No

LMP: _____ Length of Amenorrhea: _____

Weight and Height:

Current Weight: _____ kg Date Weighed: _____ (YYYY−MM−DD)

Current Height: _____ cm Date Measured: _____ (YYYY−MM−DD)

Previous Wt: Highest _____ kg Date: _____ (YYYY−MM−DD)

Lowest _____ kg Date: _____ (YYYY−MM−DD)

****** For Children and Adolescents: please attach all historicial growth curves (Height & Weights) for our team to set target weight *******

Current Psychological Status:

	Yes	No
Current Self−Harm Behaviours		
Past Self−Harm Behaviours		
Current Suicidal Ideation and/or Intent		
Past Suicidal Ideation and/or Intent		
Past Suicide Attempt		
Anxiety Symptoms		
Depressive Symptoms		

Psychiatric History:

_____

_____

Current Physical Status:

Significant Medical History: ❑ Yes ❑ No

If yes, please describe (including any diagnoses, dates and surgeries):

_____

_____

Current Medications (including prescribed, OTCs, vitamins, herbals):

_____

_____

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Physical Examination: Date (YYYY−MM−DD): _____

Pulse Lying: _____ Pulse Standing: _____

Blood Pressure Lying: _____ Blood Pressure Lying: _____

Orthostatic vitals−
Have patient *lie down* for 5 minutes then obtain BP and pulse, then retake after the patient has been standing for 5 minutes.

Investigations: (These need to be ordered and results faxed to the respective clinic)

- ❑ CBC and diff
- ❑ Lytes
- ❑ BUN
- ❑ Creatinine
- ❑ Glucose
- ❑ Amylase
- ❑ ALT
- ❑ AST
- ❑ Alkaline Phosphatase
- ❑ Phosphate
- ❑ Mg
- ❑ Calcium
- ❑ TSH
- ❑ EKG

Would any of these factors be problematic for the patient/family to attend assessment or treatment?

❑ Work/School ❑ Financial Limitations ❑ Child/Family Care

❑ Transportation ❑ Inability to Function in a group (adults)

❑ Other, please specify: _____

For Adults Only:
Level of Motivation:

❑ Does not see ED as a Problem/Denies ED

❑ Ambivalent about treatment

❑ Very Motivated/Wants ED Gone

Form of treatment requested: ❑ Inpatient ❑ Outpatient ❑ Uncertain

PLEASE FAX COMPLETE FORM TO Attn: Eating Disorders Team

Adult
Abbie J. Lane Memorial Building
5909 Veterans' Memorial Lane, Halifax
Fax: 902−473−6282

Child/Adolescent
IWK Health Centre
5850/5980 University Avenue, Halifax
Fax: 902−470−7893