

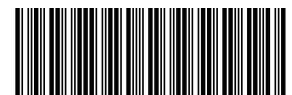
The Regional Eating Disorders Clinic is a specialized program that provides services to children, youth, adults, families and health care providers within Northern Health who are experiencing or working with those with an eating disorder.

<p>Services provided</p> <p>Local referrals (Prince George only, patient specific)</p> <ul style="list-style-type: none"> • Assessment for diagnostic purposes and treatment planning • Individual and group therapy • Meal support therapy • Nutritional therapy and support • Family support and education • Medical follow-up and Support • Consultative support and resources (inpatient / outpatient / regional settings) • Tertiary referrals, supports and liaison <p>Regional referrals (all NH communities outside of Prince George)</p> <ul style="list-style-type: none"> • Assessments for diagnostic purposes and treatment planning (all telehealth modalities available inpatient / outpatient settings) • Direct and ongoing service provider consults (all telehealth services available, inpatient/outpatient settings) • Tertiary referrals, supports and liaison 	<p>Tertiary services</p> <ul style="list-style-type: none"> • BC Children's Inpatient Eating Disorders Program: 14 beds available provincial wide; up to age 18 if still attending high school. Families are expected to be a part of treatment and stay with child/adolescent during their stay in hospital. MSP covered. • BC Children's Day Treatment Program: 6 spaces available provincial wide; up to age 18 if still attending high school. Families are expected to be a part of treatment and stay with child/adolescent during their stay in day treatment program. MSP covered. • St. Paul's Inpatient Program: 7 beds available provincial wide; age 17 years and up. MSP covered. • St. Paul's Readiness & Discovery Vista Residential Program: 8 beds available. 18 years and up. MSP covered. • Looking Glass Residence: 14 beds available; 17 to 24 years. (Applicants 19 years and up have a \$30.90 + dispensing fees/day charge.)
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Complete and fax referral to 250-645-8039. We will provide confirmation of referral within 48 hours. If fax is not available, please indicate and we will follow up via telephone. If you have any questions or concerns, please call 250-645-7440.

*****Mandatory Lab Work and ECG Must Accompany Referral*** (within the past 3 months)**

Referring agent				
Date:				
Referring doctor or nurse practitioner:				
Please indicate:	Family Physician	Nurse Practitioner	Pediatrician	Psychiatrist
MSP #:	Office phone:		Office fax:	
Office address:				
Primary Care team affiliated with:				
<p>Please indicate what services you are referring this patient for: (please complete with patient you are referring for triaging purposes)</p> <p>Regional consultative services (includes inpatient consult and all community referrals across Northern Health): Please specify:</p> <p>Assessment request for diagnostic and treatment planning purposes (includes all telehealth assessments). Telehealth assessment In-person assessment</p> <p>Service provider consult only. Group only</p> <p>Tertiary referral inquiry (Note: For tertiary services, patient must be connected with primary care practitioner and mental health services (private or public). Please indicate which site: (refer above for list of available facilities.)</p>				
Patient information				
First name:		Middle name or initial:		Surname:
Date of birth: YY MM DD		Primary Health Care Number (PHN):		Gender: Male Female Other: (please specify)
Parent or legal guardian's name(s):			Family contact information:	



Primary phone number:	Home address:	Mailing Address (if different from home address):
Secondary phone number:	Is patient aware of referral? Yes No	Is the patient agreeable to the referral? Yes No
Can we leave messages? Yes No	Is the family aware of referral? Yes No	Is the family agreeable to the referral? Yes No
Marital status: Single Married Common law Separated Divorces	Primary language:	

Eating Disorder Related Information: (For child and youth patients, *please send growth charts*)

Current height: _____ in/cm Current weight: _____ lbs/kg BMI: _____ kg/m²

Recent weight loss (how much): _____ lbs/kg

Lowest weight: _____ lbs/kg age or year _____ Highest weight: _____ lbs/kg age or year _____

Orthostatic vital signs:
Heart rate: _____ sitting Heart rate: _____ standing Blood pressure: _____ sitting _____ lying

Eating Disorder Related Behaviours

Food Restriction Binge Eating Vomiting Laxatives Diuretics Over-Exercising
Chewing and Spitting Diet pills Ipecac Insulin Abuse Other _____

Please specify frequency of behaviours: _____

Medical History:

Diabetes Pregnant Substance Use / Dependant Other _____

Current medications: _____

*****Mandatory Lab Work and ECG Must Accompany Referral***** (within the past 3 months)
(This is important to rule out other comorbid conditions. Generally some tests are only needed initially. Referral will not be processed without this, please send all labs requested with referral)

CBC Lytes (+glucose) CA MG PO4 Ferritin CR BUN
ESR(or C-Reactive Protein) TSH ECG - please send a copy with this form

Psychiatric History:

Self Harm: No Yes (please specify): _____

Suicidal Ideation / History: No Yes (please specify): _____

Please describe any psychiatric symptoms of concerns, current diagnosis and/or previous admissions:

Current Psychiatric and/or Community Supports:

Mental Health Team: Location and phone#: _____

Psychiatrist: Location and phone#: _____

Psychologist / Therapist / Counsellor: Location and phone#: _____

Other: Location and phone#: _____

I understand the Northern Health Regional Eating Disorders Clinic is an outpatient eating disorders service and is unable to assume responsibility for the primary medical care of this patient. Ongoing care is the responsibility of the primary care practitioner including any hospitalization for medical stabilization.

Primary Care Practitioner's Signature: _____ Date: _____