Referral Form

PROVINCIAL Health Services AUTHORITY
Province-wide solutions. Better health.

Provincial Specialized Eating Disorders Programs

Referring Professional:

Are you>>> ☐ GP/Family Doctor ☐ Pediatrician ☐ Psychologist ☐ Psychiatrist ☐ a Regional Program

☐ Other – specify: _____

Your MSP BILLING #: _____

Are you>>> The primary care provider? ☐Yes ☐No If No – Give name of Primary Care Provider:

Dr. _____ _____ Phone #: ( ) _____

Your name: _____ last _____ first ____ initial	**Office phone #:**	**Office fax #:**
Address City:	Postal code:	

Patient information - Personal history

Patient's legal name **(please print)** **Gender:** ☐ 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: _____

Patient's current home #: ( ) **Patient's cell #:** ( )

Patient's work # if applicable: ( ) **Other #:** ( )

BCCH only:

CAREGIVER #1		**CAREGIVER #2**	
Relationship to patient:		Relationship to patient:	
Name:		Name:	
Home tel:	Cell:	Home tel:	Cell:
Email:		Email:	

Current 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 & #: _____

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

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 ➞ **Send a copy with this form.**

Describe any other medical issues:

Psychiatric history ✹ Previous psychiatric consults or reports required

Describe any psychiatric issues or previous admissions:

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.

➞ Information enclosed on and with this referral will be shared with the designated secondary or tertiary service in the patient's health region