# Regional Eating Disorders Program: Client Referral Form

In the continuum of care for eating disorders treatment on Vancouver Island, this referral form is shared by all Island Health Outpatient Eating Disorder Programs. Inclusion criteria may vary by program (see below boxes).

The following are generalized Exclusion criteria:

a) The client is actively suicidal
b) Non-eating disorder psychiatric disorders account for decreased food intake (i.e. thought disorders with delusions around food)
c) Alcohol or substance misuse is the primary presenting problem

Recognizing there is complex comorbidity in this population, contact the Manager – Crystal Frost for further discussion if needed 250-519-6925

**Please read the following guidelines carefully – For the most current program information/Referral Form, check *Pathways* with the Divisions of Family Practice**

## Referring to Central Island Child & Youth Eating Disorders Program:

- Clients 18 years of age & younger with confirmed or suspected eating disorder as outlined in the DSM V: Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED), Avoidant Food Intake Disorder (ARFID) and Other Specified Feeding & Eating Disorder (OSFED)
- Referrals are accepted from General Practitioners, Nurse Practitioners & Pediatricians for those 13-19 years of age
- Those 12 years of age & under require a Pediatrician referral.
- Referrals are accepted from Geography 2 including the following regions: Ladysmith, Nanaimo, Gabriola Island, Oceanside, Alberni Valley, West Coast

**Fax referral to: 250-716-1854**
Phone Number: 250-618-9962

## Referring to Central Island Adult Eating Disorders Program:

- Clients 19 years of age & older with confirmed or suspected eating disorders as outlined in the DSM V: Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED), Avoidant Food Intake Disorder (ARFID) & Other Specified Feeding & Eating Disorders (OSFED)
- Referrals accepted from General Practitioners and Nurse Practitioners
- Referrals accepted from the following regions: Ladysmith, Nanaimo, Gabriola Isl., Oceanside, Alberni Valley, West Coast

**Fax Referral to: 250-850-2639**
Phone Number: 250-739-5880 X 56117

## Referring Clients to North Island Eating Disorders Program (Youth & Adults):

- Clients with confirmed or suspected eating disorder as outlined in the DSM V: Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED) and Other Specified Feeding & Eating Disorder(OSFED)
- Referrals are accepted from General Practitioners, Nurse Practitioners and Pediatricians
- Referrals are accepted from Geography 1 regions: Comox Valley, Strathcona, Campbell River, North Island, Mount Waddington, Gold River, Tahsis, Cortez Isl, Quadra Isl

**Fax referral to: 250-850-2639**

Comox Valley Phone Number: 250-331-5900 X 65325
Campbell River Phone Number: 250-286-7100 X 62867

## Referring Clients to Cowichan Valley Adult Eating Disorders Program:

- Clients 19 years of age and older with confirmed or suspected eating disorder as outlined in the DSM V: Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED), Avoidant Food Intake Disorder (ARFID) and Other Specified Feeding & Eating Disorder (OSFED)

- Referrals are accepted from General Practitioners, Nurse Practitioners and Pediatricians
  Referrals are accepted from Shawnigan Lake, Duncan, Chemainus, Lake Cowichan , North Cowichan, Mill Bay, Ladysmith

**Fax referral to: 250-850-2639**

Phone Number: 250-732-2376

***For youth in Cowichan Valley, Child & Youth Mental Health (CYMH) provides Eating Disorder services with a separate referral form. Phone Number: 250-715-2725 Fax 250-715-2789**.

***Please note: Eating Disorder Program – South Vancouver Island is operated under the Ministry of Children & Family Development (MCFD). Phone Number 250-387-0000 Fax 250-387-0002. There is a separate referral form located on Pathways with the Divisions of Family Practice for the Eating Disorders Program - South Vancouver island.***

To connect with the Island Health Regional Eating Disorders Manager call:
250-519-6925 or email: crystal.frost@islandhealth.ca

## Where are you referring? (Select one):

☐ Central Island Child & Youth Eating Disorders Program/ Fax referral form to: 250-716-1854

☐ Central Island Adult Eating Disorders Program / Fax referral form to: 250-850-2639

☐ North Island Eating Disorders Program / Fax referral form to: 250-850-2639

☐ Cowichan Valley Eating Disorders Program / Fax referral form to: 250-850-2639

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*Referring Primary Care Provider Information – All patients must have a GP, NP, or Walk-In Clinic that will follow them. The Information provided will be used for triaging purposes.*

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Date

Doctor's Name

(First) Office Phone

Office Fax

Office Address

City

Postal Code

Doctor's Name

Office email address

Dr Office Stamp:

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*Client Information*

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Is client aware and in agreement of this referral for eating disorder services Yes ☐ No ☐

If Youth, is the parent also aware Yes ☐ No ☐

Legal Last Name

Middle Names(s)

Legal First Name

Preferred Name

Date of Birth

Gender ☐ Male ☐ Female ☐ Non-Binary ☐ Trans ☐ Other

BC PHN

Street Address

City / Postal Code

Client Phone Number (home) Cell/other:

OK to leave voicemails? ☐ Yes ☐ No OK to leave voicemails? ☐ Yes ☐ No

Email address:

If referring for youth, Parent Name and Contact

OK to leave messages ☐ Yes ☐ No

Are you referring to another service in conjunction with this referral? ☐ Yes ☐ No

(If Yes Specify:)

*Eating Disorder Related Information – to be completed by primary care provider*

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Measured Height ☐ In ☐ cm Measured Blinded Weight: ☐ lbs ☐ kg

Please send growth chart if under 18 years of age

Any weight loss in the past 3 months ☐ Yes Amount ☐ No

Any weight loss in the past 6 months ☐ Yes Amount ☐ No

Heart Rate Lying (5 min):_____ Standing:

Orthostatic BP Lying (5 min):_____Standing:

Fear of Weight Gain ☐ Yes ☐ No

Restriction ☐ Yes ☐ No

Eating less than 1 meal equivalent/day ☐

Eating less than 2 meal equivalent/day ☐

Eating less than 3 meal equivalent/day ☐

Over-Exercise ☐ Yes ☐ No Current # hours/day

Self Induced Vomiting ☐ Yes ☐ No

How many times per day

How many days per week

Blood in emesis ☐ Yes ☐ No

Medications for Weight Loss ☐ Yes ☐ No
Laxative abuse ☐ Type and frequency
Insulin ☐ Details
Ipecac ☐ Details
Stimulants ☐ Details
Diet Pills ☐ Details
Diuretics ☐ Details
Thyroid meds ☐ Details

Binge Eating (objectively large amount eaten within any 2 hour period that feels out of control)
☐ Yes ☐ No How many times per day_____How many days per week

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*Medical History - to be completed by primary care provider*

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Amenorrhea ☐ Yes ☐ No Date of last period
If amenorrheic > 6 months, please order DEXA/BMD Scan and forward results

Birth Control Pills ☐ Yes ☐ No
Pregnant ☐ Yes ☐ No Week of pregnancy at referral
Diabetes (insulin dependent) ☐ Yes ☐ No Details
GI Disorder (e.g. Crohn's, Celiac, GERD) ☐ Yes ☐ No Details
Substance/ETOH Misuse ☐ Yes ☐ No Details
Other Medical Concerns (please specify)

Current Medications (please list type & dosage)

Confirmed Allergies

***Mandatory Labwork & ECG Must Accompany Referral – please forward current results:**
CBC, Random Glucose, Na, K+, Cl, Bicarbonate, Ca, Mg, PO4, Ferritin, B12, Cr, BUN, AST, ALT, Alk Phos, TSH, Microscopic urinalysis to include specific gravity (LH, FSH, estradiol if genetically female, testosterone if genetically male)
ECG – For Baseline

**Attached** ☐

**Requisition given to client** ☐

## *Psychiatric History*

Please describe any psychiatric symptoms of concern, or current diagnoses

Self Harm ☐ Yes ☐ No Please describe

Suicidal Ideation ☐ Yes ☐ No

Current or Past Suicide Attempts (when & how)

Previous hospitalizations or tertiary care admissions related to mental health or eating disorder concerns:

Perceived readiness for eating disorder treatment:

Currently working with other therapists or clinicians ☐ Yes ☐ No

If yes, names of Clinician/Therapist(s)

Physician/NP DSM 5 Diagnosis:

Anorexia Nervosa, Restricting type (AN/R) ☐

Anorexia Nervosa, Binge/Purge type (AN/BP) ☐

Bulimia Nervosa ☐

Avoidant Restrictive Food Intake Disorder (ARFID) ☐

Binge Eating Disorder (BED) ☐

Other Specified Feeding & Eating Disorder (OSFED) ☐

**Please include any recent pertinent consults/assessments and a summary note of your concerns**

Does Client have a Case Manager involved? ☐ Yes ☐ No

If client consents to Eating Disorders Services contacting Case Manager, please provide their name and contact info:

## *Routine Medical Monitoring*

1. Regular supportive meeting to check-in regarding meals, eating disorder behaviours, and medical symptoms
    a. BLIND (backwards) weight, with no mention of numbers or body appearance, is recommended to avoid triggering relapse or worsening of symptoms
    b. Postural vital signs (lie supine x 5 minutes then take BP and HR. Stand x 2 minutes then take BP and HR)

**The Central Island Child & Youth Eating Disorders Program can provide regular monitoring of weight and vitals as indicated*

2. Routine investigations: ECG and bloodwork including CBC, electrolytes, Ca, Mg, PO4, kidney function, liver function and random glucose.

NOTE: Frequency of visits and investigations depends on symptoms and clinical judgment (for example, frequency of purging or restriction with rapid weight loss needs close monitoring (q 1-2 weeks), whereas patients with less severe behaviors can be monitored less frequently (q 4-8 weeks). Please see the Eating Disorders Toolkit for Primary Care Practitioners: https://rise.articulate.com/share/9toVeBz76parmrHzWJD8pXGCWmNbmKrx#/lessons/eyj1o_zAtgHNOqDALT4_FIl688OvRZGl

## *Disclaimer*

☐ I understand that the eating disorder program is an outpatient eating disorders service and is unable to assume responsibility for the primary medical care of this client. Ongoing primary care is the responsibility of the Primary Care Provider.

Primary Care Provider's Signature Date