MINISTRY OF CHILDREN AND FAMILY DEVELOPMENT
EATING DISORDERS PROGRAM SOUTH VANCOUVER ISLAND (EDP SVI)
#302 – 2955 Jutland Road Victoria BC V8T 5J9
TELEPHONE (250) 387-0000 FAX (250) 387-0002

## PROGRAM OPTIONS

| SOUTH VANCOUVER ISLAND RESIDENTS | UNIVERSITY OF VICTORIA (UVIC) STUDENTS |
|---|---|
| ☐ | ☐ |
| **FAX: 250-387-0002** | **FAX: 250-721-6224** |

## REFERRAL CRITERIA

EDP SVI provides treatment to individuals with eating disorders as outlined in the DSM-5 TR. The program serves people of all ages with Anorexia nervosa (AN), Bulimia nervosa (BN), Avoidant Restrictive Food Intake Disorder (ARFID), and Other Specified Feeding or Eating Disorder (OSFED). Treatment for Binge Eating Disorder (BED) is available only to individuals under 19 years old.

Individuals must be residents of South Vancouver Island or Southern Gulf Islands (excluding Gabriola). This includes Greater Victoria, lower Malahat Region, and the Southern Gulf Islands of Mayne, Pender, Salt Spring and Saturna.

## EXCLUSION CRITERIA

EDP SVI does not provide services for the following instances:

1. If alcohol or substance abuse are the primary presenting problems.
2. If the client is actively suicidal or in crisis.
3. If acute psychiatric disorders account for decreased food intake such as:
   -Thought Disorders, such as when schizophrenia leads to delusions around food
   -Major Depression or Post-Partum Depression, such as when decreased food intake is due to mood

## ROUTINE MEDICAL MONITORING GUIDELINES (FOR PRIMARY CARE PROVIDERS)
## Eating Disorders Toolkit Available on Pathways

1. Regular supportive meeting to check-in regarding meals, eating disorder behaviours, and medical symptoms:
   a. BLIND (backward) weight, with no mention of numbers OR body appearance, is recommended to avoid triggering relapse or worsening of symptoms.
   b. Postural vital signs

2. Routine investigations: ECG and bloodwork including CBC, electrolytes, calcium, magnesium, phosphorus, kidney function, liver function and random glucose.

   NOTE: Frequency of visits and investigations depends on symptoms and clinical judgement (for example, frequent purging or restriction with rapid weight loss needs close monitoring (q1-2 weeks), whereas patients with less severe behaviours can be monitored less frequently (q4-8 weeks).

**The EDP SVI GPs are available for consultations with community care provider's upon request – please call 250-387-0000 to arrange.**

BRITISH COLUMBIA

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## REFERRING PHYSICIAN INFORMATION - All patients must have a GP, NP, or walk-in clinic that will follow the patient

DATE
DOCTOR'S NAME (FIRST)
DOCTOR'S NAME (LAST)
OFFICE PHONE
OFFICE FAX
OFFICE ADDRESS
CITY / POSTAL CODE

OFFICE STAMP

## CLIENT INFORMATION

LEGAL LAST NAME
LEGAL FIRST NAME
PREFERRED NAME
SEX Male ☐ Female ☐
GENDER/PRONOUNS
BC PHN
BIRTHDATE
AGE

ADDRESS/ POSTAL CODE
PHONE NUMBER Can we leave voicemails? Yes ☐/ No ☐
PHONE NUMBER (Alt) Can we leave voicemails? Yes ☐/ No ☐
EMAIL ADDRESS:

## IF CHILD/YOUTH (<18)

GUARDIAN NAME(S)
RELATION TO PATIENT
PHONE NUMBER
EMAIL ADDRESS
AWARE OF REFERRAL? Yes ☐/ No ☐

## PHYSICAL EXAM + SYMPTOM REVIEW

HEART RATE Supine Standing
BLOOD PRESSURE Supine Standing

CURRENT HEIGHT In ☐ / cm ☐
CURRENT WEIGHT lbs ☐/ kg ☐
CURRENT BMI

WEIGHT CHANGES Yes ☐/ No ☐
Amount of weight lost in the last 3 months:
Amount of weight lost in the last 6 months:

RESTRICTION Yes ☐ / No ☐ SEVERITY
☐ 500-1000 calories per day
☐ 1000-1500 calories per day
☐ Other (describe):

PURGING Yes ☐ / No ☐ FREQUENCY
☐ Weekly
☐ Once per day
☐ Multiple times per day

MEDICATION FOR WEIGHTLOSS Yes ☐ / No ☐ TYPE
☐ Diet Pills ☐ Laxatives ☐ Diuretics
☐ Thyroid Medications ☐ Ipecac
☐ Other (describe):

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| SYMPTOM REVIEW - CONTINUED | | |
|---|---|---|
| FEAR OF WEIGHT GAIN | Yes ☐ / No ☐ | |
| OVER-EXERCISE | Yes ☐ / No ☐ | |
| BINGE EATING | Yes ☐ / No ☐ | |
| ARFID SUSPECTED | Yes ☐ / No ☐ | → If no, skip NIAS screen and proceed to next page<br>→ If yes, complete NIAS screen below |

## NINE ITEM AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER SCREEN (NIAS)

| Picky Eating Subscale | | 0 Strongly Agree | 1 Disagree | 2 Slightly disagree | 3 Slightly agree | 4 Agree | 5 Strongly agree |
|---|---|---|---|---|---|---|---|
| 1 | I am a picky eater. | | | | | | |
| 2 | I dislike most foods that other people eat. | | | | | | |
| 3 | The list of foods that I like and will eat is shorter than the list of foods I won't eat. | | | | | | |
| | | | | | | Total: | |

| Appetite Subscale | | 0 Strongly Agree | 1 Disagree | 2 Slightly disagree | 3 Slightly agree | 4 Agree | 5 Strongly agree |
|---|---|---|---|---|---|---|---|
| 1 | I am not very interested in eating; I seem to have a smaller appetite than other people. | | | | | | |
| 2 | I have to push myself to eat regular meals throughout the day, or to eat a large enough amount of food at meals. | | | | | | |
| 3 | Even when I am eating a food I really like, it is hard for me to eat a large enough volume at meals. | | | | | | |
| | | | | | | Total: | |

| Fear Subscale | | 0 Strongly Agree | 1 Disagree | 2 Slightly disagree | 3 Slightly agree | 4 Agree | 5 Strongly agree |
|---|---|---|---|---|---|---|---|
| 1 | I avoid or put off eating because I am afraid of GI discomfort, chocking, or vomiting. | | | | | | |
| 2 | I restrict myself to certain foods because I am afraid that other foods will cause GI discomfort, choking, or vomiting. | | | | | | |
| 3 | I eat small portions because I am afraid of GI discomfort, choking, or vomiting | | | | | | |
| | | | | | | Total: | |

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## MEDICAL HISTORY

DIABETES Yes ☐ / No ☐ _____
INSULIN USE Yes ☐ / No ☐ _____
PREGNANT Yes ☐ / No ☐ _____
AMENORRHEA Yes ☐ / No ☐ If occurring for > 6 months, please order BMD
SUBSTANCE USE Yes ☐ / No ☐ _____
CURRENT MEDICATIONS _____
_____
ALLERGIES _____

## PSYCHIATRIC HISTORY

SELF HARM Yes ☐ / No ☐ _____
SUICIDALITY Yes ☐ / No ☐ _____

SEE EXCLUSION CIRTERIA – patients experiencing suicidality require a referral to general mental health or crisis services

DIAGNOSES: _____
_____

## MANDATORY LABWORK & ECG MUST ACCOMPANY REFEERAL

☐ CBC | Random Glucose | Na | K | Cl | Bicarbonate | Ca | Mg | PO4 | Creatinine | BUN | AST | ALT | TSH | EKG |
| Microscopic Urinalysis to include Specific Gravity |

## DISCLAIMER

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

PRIMARY CARE PROVIDER'S SIGNATURE _____ DATE _____