# Alexandra Marine & General Hospital
# Huron Outreach
# Eating Disorders Program

| **Date**: | **Health Card#** | **Version**: |
|---|---|---|

| **Name**: | **DOB**: | **Gender**: | **Age**: |
|---|---|---|---|
| **Mailing Address**: | **911 Address**: | | |
| **Postal Code**: | Mail Correspondence accepted: ☐ Yes ☐ No | | |
| **Telephone Number** (primary):<br>Messages can be left? ☐ Yes ☐ No | **Telephone Number**(secondary):<br>Messages can be left? ☐ Yes ☐ No | | |

| | |
|---|---|
| **Referral Source**: | **Agency**: |
| **Phone:** | **Is client aware of this referral**? ☐ Yes ☐ No |
| **Emergency Contact (parental information if adolescent)**: | **Relationship**: |
| **Address**: | **Telephone Number**: |
| **Allergies:** ☐ **Yes No** ☐ **If yes, specify:** | |

| | | |
|---|---|---|
| **Family Physician**: | **Phone**: | Last Seen: |
| **Psychiatrist** : | **Phone:** | Last Seen: |

**Other Providers:**

**Reason for Referral**:

**Medication List:**

**Has client received treatment/counselling for eating disorder in the past**? ☐ Yes ☐ No

**Is family physician aware client is struggling with an eating disorder: Yes** ☐ **No** ☐

**Is there a diagnosis: BN AN EDNOS other:**

| | |
|---|---|
| **Are there any barriers to accessing service** (Language, communication, physical, visual etc.)? | ☐ Yes ☐ No : **If yes, specify:** |

**Identify Eating Disorder symptoms/concerns:**

| | | | | | |
|---|---|---|---|---|---|
| Food Restriction | ☐ Yes | ☐ No | Binge Eating | ☐ Yes | ☐ No |
| *Frequency* | | | *Frequency* | | |
| Vomiting | ☐ Yes | ☐ No | Laxatives/diuretics | ☐ Yes | ☐ No |
| *Frequency* | | | *Frequency* | | |
| Diet Pills | ☐ Yes | ☐ No | Exercising | ☐ Yes | ☐ No |
| *Frequency* | | | *Frequency* | | |

Other

**Is the individual experiencing any health concerns such as**:

| | | | | | |
|---|---|---|---|---|---|
| Absence of Menses | ☐ Yes | ☐ No | Cold Intolerance | ☐ Yes | ☐ No |
| *Frequency* | | | *Frequency* | | |
| Dizziness/light headedness | ☐ Yes | ☐ No | Passing Out | ☐ Yes | ☐ No |
| *Frequency* | | | *Frequency* | | |
| Hair Loss | ☐ Yes | ☐ No | Edema | ☐ Yes | ☐ No |
| *Frequency* | | | *Frequency* | | |
| Poor circulation in extremities | ☐ Yes | ☐ No | Shortness of Breath | ☐ Yes | ☐ No |
| *Frequency* | | | *Frequency* | | |
| Dental erosion/caries | ☐ Yes | ☐ No | Poor concentration/memory | ☐ Yes | ☐ No |
| *Frequency* | | | *Frequency* | | |
| Social isolation | ☐ Yes | ☐ No | | | |
| *Frequency* | | | | | |

Other:

**Self Injury History**

| | | | |
|---|---|---|---|
| Suicide attempt | ☐ Yes | ☐ No | Comments |
| Self-harming | ☐ Yes | ☐ No | Comments |
| Substance Abuse | ☐ Yes | ☐ No | Comments |

Other

**Safety Risks**

| | | | | | |
|---|---|---|---|---|---|
| Current or past charges: | ☐ Yes | ☐ No | Safety Risk: | ☐ Yes | ☐ No |
| History of harm to people/property: | ☐ Yes | ☐ No | No Identified Risk: | ☐ Yes | ☐ No |

**Comments:**

*****If Physician / Family Health Team Referral, complete the following:***

Current Weight: Height: BMI:

Recent Blood Work: ☐ Yes ☐ No Date Completed:

Abnormal findings? K+ Phos Gluc CR Urea Amylase other

Recent ECG ☐ Yes ☐ No Date Completed:

Recent Vital Signs: Temperature: Sitting: HR: BP:

Standing: HR: BP:

******If the above cannot accompany the referral please arrange for testing and forward results as this will reduce wait time for service***.

**Psychiatric Issues / Diagnosis:**

**Previous Hospitalization:** ☐ Yes ☐ No Comment:

**Huron Perth Helpline and Crisis Response Team phone number provided?**: ☐ Yes ☐ No **1-888-829-7484**

**Individual given information on the importance of seeing her family physician for a physical? Yes ☐ No ☐**

**Fax the Completed Form to 519-524-9349.**