Soldiers' MEMORIAL HOSPITAL Orillia

PAEDIATRIC EATING DISORDERS PROGRAM - INTAKE/REFERRAL FORM

Today's Date: _____ Health Card # _____

Patient's Name: _____ DOB: _____/_____/_____
Day Month Year

Address: _____Postal Code: _____

Parents' Names: _____

Phone #: (Res) _____

Referring Physician: _____ Address: _____

Phone #: _____ FAX #: _____

PRESENTING PROBLEM(S): (i.e., restricting, bingeing etc.)

1. _____
2. _____
3. _____

HISTORY OF PREVIOUS MEDICAL/MENTAL HEALTH ISSUES:

1. _____
2. _____
3. _____

Please send all previously recorded height and weight measurements

WEIGHT: Present _____kg Highest _____kg Lowest _____kg

Date: _____ Date: _____ Date: _____

HEIGHT: Present _____cm Date: _____

MENSES: Menarche: _____

LMP: _____

WEIGHT CONTROL	METHODS		FREQUENCY	
	No	Yes	Per Day	Per Week
Food Restriction				
Binge				
Vomiting				
Laxatives				
Diuretics				
Ipecac				
Diet Pills				
Exercise				

RESULTS OF RECENT LAB WORK: ☐ Please attach results to referral/intake form

☐Sodium ☐Potassium ☐Chloride ☐Glucose ☐BUN/Creatinine ☐ALT ☐Calcium ☐Magnesium ☐Phosphorus ☐Albumin ☐Total Protein ☐Ferritin ☐TSH ☐CBC/diff. ☐ESR ☐Amylase ☐LH ☐FSH ☐T4/TSH

ECG ☐ (Must be attached for appropriate triaging)

MEDICATIONS:

Prescribed:

_____

Non-prescribed:

_____

MEDICAL STABILITY: (Please note this information in addition to ECG and Bloodwork required to triage appropriately)

ORTHOSTATIC BLOOD PRESSURE	**ORTHOSTATIC HEART RATE**
Lying Standing	Lying Standing
Date	Date

Please return form to: The Paediatric Eating Disorder Program
Orillia Soldiers' Memorial Hospital

170 Colborne St. West, Orillia, ON L3V 2Z3
Phone: (705) 325-2201 extension 3558
Fax: (705) 330-3229