St. Joseph's Healthcare Hamilton Eating Disorders Program

St. Joseph's Healthcare Hamilton
50 Charlton Ave. East
Juravinski Innovation Tower, 9th floor
Hamilton, Ontario L8N 4A6

Michele M. Laliberte, Ph.D. (Director)
Kofi Ofosu, MD, FRCPC (Medical Director)
Helen Mahon, Secretary

INTAKE WORKER:
CALL Debbie Casperson at 905-522-1155 Ext. 33954
Fax # 905-521-6131

BEFORE COMPLETING PLEASE READ:

- Referral to the program is for consultation and treatment recommendations. Treatment will be offered if appropriate. **This program is not suitable for everyone.**

- **A patient is appropriate for referral if you suspect that she/he has an eating disorder and has a Body Mass Index (BMI) of 16 or more.**

- St. Joseph's Healthcare Hamilton Eating Disorders Program is an outpatient, GROUP BASED program. **We do not offer inpatient treatment or day treatment at this time.** If you believe that your patient requires intensive treatment or could in the foreseeable future, please begin a referral to: The Homewood Health Centre in Guelph (for BMI 15+), Toronto General Hospital Eating Disorder's Program, or the Credit Valley Program in Mississauga.

- **You must include the results of the following investigations with the referral form. The reports must be current.**

Where symptoms include: food restriction, purging of any kind, fluid restriction, excessive exercise, insulin under-use, or use of any substance for weight loss purposes, please complete the following investigations:	Where person is BINGE EATING ONLY, please complete the following investigations:
CBC + diff Electrolytes, Calcium, Magnesium, Phosphate Glucose Urea, Creatinine AST, ALT, GGT, Alkaline Phosphatase, Albumin Vitamin B12 TSH Ferriten E.C.G.	CBC + diff Electrolytes Urea and Creatinine AST,ALT,GGT & Alkaline Phosphatase Vitamin B-12 TSH Ferritin FASTING Glucose & Lipids ECG

- **THE FAMILY PHYSICIAN IS RESPONSIBLE FOR THE MEDICAL MONITORING OF THEIR PATIENT WHILE IN THE PROGRAM AT ST. JOSEPH'S HEALTHCARE HAMILTON.** *Suggested Medical Monitoring Guidelines attached.

Referral Form

If you would like to refer a patient to the program, please complete the following two pages and return this form by mail or fax (905-521-6131) to Debbie Casperson, Intake Worker.

Date of Referral: _____/_____/_____
dd mm yy

Referring Physician: _____

Address: _____

Tel: ( )_____ Fax: ( ) _____

Back Line #_____

Physician's Billing Number_____ Signature _____

Patient Last Name:_____ **First Name:** _____**Initial:**_____

Address (number & street): _____

City:_____ Postal Code:_____ OHIP Number:_____

Tel: Home (_____)_____ Work (_____)_____

Email address:_____

Date of Birth: d_____m____y_____ Gender: Female ( ) Male ( ) Age:_____

Current Symptoms (**check all that apply**): Please ask patient if you are uncertain

( ) Restricting Food Intake
( ) Binge Eating
( ) Compensating for Food Intake by:
- ( ) vomiting ( ) insulin restriction ( ) diet pills or herbal weight loss remedies
- ( ) laxatives ( ) diuretics ( ) extreme exercise
- ( ) ipecac ( ) abuse of thyroid meds

( ) extreme distress with weight and shape

Current Physical Status (please complete all information)

Height: _____ Weight: _____ B.M.I.: _____

Weight Loss ( ) or Weight Gain ( ) (CHECK ONE) of _____ lbs/kg) over_____(time period)

Date of last menstrual period? _____

BP _____ Pulse _____

Has this patient ever received treatment for his/her eating disorder? Yes ( ) No ( )
Please describe:

Do you feel this patient needs inpatient care? Yes ( ) No ( )
Have you begun a referral to an inpatient program? Yes ( ) No ( )

If yes, to where: _____

What is the anticipated admission date: _____

Does this patient have any other known medical illness: Yes ( ) No ( )
Please describe:

After our assessment, you will be sent specific medical monitoring recommendations for your patient. In the meantime, please refer to the general medical monitoring guidelines that were sent with this referral form. If you did not receive these guidelines, please contact the program and ask for a copy to be faxed to you.

Current Psychiatric Status (Please complete <u>all</u> information)
Does this patient have other known psychiatric concerns? Yes ( ) No ( )
Please describe:

Does this patient have (check all that apply):
( ) Current substance abuse ( ) History of substance abuse
( ) Current self-injurious behavior ( ) Past self-injurious behavior

Is this patient in treatment with another mental health professional? Yes ( ) No ( ) Unsure ( )

If yes, please name mental health professional: _____

HAS THE PATIENT INDICATED ANY CONCERNS REGARDING CONFIDENTIALITY (e.g., leaving messages at their home)? YES ( ) NO ( )
IF YES PLEASE CLARIFY:

Please attach any other information you feel relevant.

Thank you.