EATING DISORDERS PROGRAM OUTREACH SERVICE

Stratford General Hospital
Special Services Unit
& Eating Disorders Program, London Health Sciences Centre
Please fax completed form to 519-272-8226

REFERRAL FORM

Date: _____

Name: _____ DOB: _____ HC#: _____

Address: _____ City _____ PC: _____ Ph#: _____

Referring Physician: _____ Ph#: _____ Fax#: _____

Family Physician: _____ Ph#: _____ Fax#: _____

Presenting Problems (Food restriction, Binge eating, Laxative use, History of weight loss, etc.):

Past Medical History:

Psychiatric History (suicidal behaviour, OCD, depression, etc.):

Functional Inquiry:

Allergies:

Current Medications (includes BCP, vitamins, laxatives, etc.):

Menstrual History (Menarche, LNMP):

Drug & Alcohol Use:

Significant Family Illness:

Physical Examination (in gown, no shoes): Weight: _____ Height: _____BP (lying): _____
Pulse (lying): _____ BP (standing): _____ Pulse (standing): _____ Temp: _____
General Appearance (Lanugo, parotid gland enlargement, dental issues, etc):

Previous Treatment for Eating Disorder:

Other Comments:

PLEASE INCLUDE THE FOLLOWING LABORATORY INVESTIGATIONS:

Potassium	sodium	calcium	magnesium
BUN	CBC	amylase	TSH
Creatinine	liver functions	phosphate	glucose

Other Investigations as needed: Biochemistry (LH, FSH, ferritin, cholesterol) Virology Bacterology X-ray

Other Consultations: _____
Follow-up: _____

Signature of Physician: _____