Fraser Health Eating Disorders Program
(Fraser South, Fraser North, Fraser East)
Central Intake: #129 - 6345 120 Street, Delta, V4E *2A6*
Phone: 604-592-3700 Fax: 604-591-2302

REFERRAL FORM – ADULT CLIENTS
Fraser North, Fraser South & Fraser East

IMPORTANT INFORMATION:

- The Fraser Health Eating Disorders Program services clients 18.5 years and older, with eating disorders as outlined in the DSMV, who reside within the Fraser Health Authority: Surrey, White Rock, Delta, Langley, Aldergrove, Burnaby, New Westminster, Tri-cities, Maple Ridge, Pitt Meadows, Abbotsford, Mission, Chilliwack, Agassiz, Hope.
- Please ensure regular in-person medical visits with your patient. The Eating Disorders Program is a specialized program and not primary care. Medical monitoring information and a toolkit will be sent to the primary care physician.
- All required lab work & an ECG (completed within 3 months) must accompany the referral form. This will assist us in determining the urgency of the referral.
- Referred clients must attend an Information Session, which is held on the 2nd & 4th Wednesday of each month from 3-4:30 pm via Zoom. Families/supports are encouraged to attend with them.

EXCLUSION CRITERIA:

1. The client is acutely suicidal or in crisis. Please refer client to general Mental Health services.
2. Anyone under the age of 18.5 should be referred to the Child & Youth Eating Disorders Program in their region.

Fraser South
129-6345 120 Street
Delta, BC V4E 2A6
604-592-3700

Fraser North
300-3003 St. John's Street
Port Moody, BC V3H 2C4
236-468-2373

Fraser East
45470 Menholm Rd, Chilliwack
604-702-4860
11-32700 George Ferguson Way,
Abbotsford 604-870-7800

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REFERRAL FORM – Adult Clients
Fraser North, Fraser South & Fraser East

FAX TO: *604-591-2302*

Referring Physician (All patients must have a GP, NP or Walk-in Clinic that will follow them.)

Referring Doctor's Name: _____ _____ MSP: _____
LAST NAME **FIRST NAME**

Office Phone: _____ **Fax:**_____

Address: _____

_____ _____
CITY **POSTAL CODE**

Primary Care Physician (if different from above): _____ _____
NAME **PHONE/MSP #**

Client Information

Patient's Legal Name (Please print) ☐ Male ☐ Female ☐ Other _____

_____ _____ _____ _____
LAST NAME **FIRST NAME** **MIDDLE NAME** **PREFERRED**

BC PHN# (Mandatory) _____ **DOB:** _____ /_____/_____ _____
DD MM YYYY Age

Patient's Current Address:

Street _____ **Apt #** _____ **City** _____ **Postal Code** _____

Contact Information: **Home #:** _____ **Client's Cell/Other:** _____

Can we leave a message? ☐ **Yes** ☐ **No** **Can we leave a message?** ☐ **Yes** ☐ **No**

Email Address: _____ **Primary Language:** _____

Eating Disorder Related Information:

Current Height: _____ in/cm Current Weight: _____ LBS/KG Recent Weight loss (how much?) _____
Please state time frame of wt. loss (i.e. # of months) _____

Lowest WT: _____LBS/KG Age or Year _____ Highest WT: _____LBS/KG Age or Year _____

Heart rate: _____ _____ (Orthostatic) BP: _____ _____
Lying Standing Lying Standing

FRASER SOUTH
129-6345 120 Street
Delta, BC V4E 2A6
604-592-3700

FRASER NORTH
300-3003 St. John's Street
Port Moody, BC V3H 2C4
236-468-2373

FRASER EAST
45470 Menholm Rd, Chilliwack
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11-32700 George Ferguson Way, Abbotsford 604-870-7800

Eating Disorder-Related Behaviours:

☐ Restriction ☐ Bingeing ☐ Vomiting ☐ Laxatives ☐ Diuretics ☐ Over-exercising ☐ Chewing & Spitting ☐ Diet Pills

☐ Ipecac ☐ Insulin misuse ☐ Suspect ARFID ☐ Other _____

Please specify frequency of above behaviours: _____

Medical History: ☐ **Diabetes** ☐ **Pregnant** ☐ **Substance Use/Dependent** ☐ **Other**

Amenorrhea ☐ Yes ☐ No ☐ LMP_____ **History of Amenorrhea** ☐ Yes ☐ No
(Loss of menses for at least 3 months)

Describe any other medical issues:

Current Medications:

**** Mandatory Lab Work & ECG Must Accompany Referral****

This is important to rule out other comorbid conditions. Generally, some tests are only needed initially. Referral will not be processed without this.

• CBC • Random (+glucose) • CA • MG • PO4 • Ferritin • CR • BUN • ESR or C-Reactive Protein • TSH • ALT • AST
• Sodium • Potassium • Chloride • Bicarbonate • Microscopic Urinalysis to include Specific Gravity
• ECG – Please provide a copy with this referral

Psychiatric History: ☐ **Self harm** ☐ **Suicidality (See exclusion criteria - Patients who are currently suicidal require a referral to MH)**

Please describe any psychiatric symptoms of concern, current diagnosis or previous admissions:

Current psychological or psychiatric treatment: (attach existing consultation reports if available)

☐ St. Paul's Hospital ED Program

☐ Mental Health Team Location & # _____
☐ Psychiatrist Name & # _____
☐ Psychologist/Therapist/Counsellor Name & #: _____
☐ Other Name & # _____

Have you also made a referral to:

☐ Looking Glass Residence
☐ St. Paul's Hospital ED Program
☐ Any other psychiatric program? _____

□ I understand that the Fraser Health Eating Disorders Program 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 including any hospitalization for medical stabilization.

_____ _____

Primary Care Provider's Signature **Date**