South Fraser Eating Disorders Program
#29-6345 120th Street
Delta, B.C. V4E 2A6
Phone: 604-592-3700
Fax: 604-591-2302

# Child and Youth Referral Criteria

## IMPORTANT INFORMATION

- The Eating Disorders Program services clients with eating disorders as outlined in the DSM-V.
- The Eating Disorders Program is not a substitute for a client's General Practitioner. Please ensure regular visits with your client. Medical monitoring information will be sent to the referring physician. The eating disorders toolkit is available for download.
- We accept referrals where the *eating disorder is the primary diagnosis.*
- **All required recent (within the last 3 months) lab work & an ECG must accompany the referral form.** This will assist us in determining the urgency of the referral.
- Referrals from Hospital must complete page 4 – indicating the patient's Primary Physician upon discharge.

## EXCLUSION CRITERIA

**The Eating Disorders Program does not provide services in the following instances:**

- Alcohol or substance abuse is the primary presenting problem.
- The client does not have a General Practitioner or Nurse Practitioner.
- The client is actively suicidal or in crisis. In this case, please refer to the START program at **1-844-782-7811 (1-844-START11**)
- Acute psychiatric disorders that account for decreased food intake, such as:
  - Thought Disorders (e.g., someone with Schizophrenia who has delusions around food).
  - Major Depression or in instances where decreased food intake is due to mood.
- The client is not a resident of the following communities: Surrey, White Rock, Delta, Langley, or Aldergrove. Please call **604-592-3700** if you would like the referral form for the Fraser North Program.

## EATING DISORDERS TOOKLIT FOR PRIMARY CARE PROVIDERS – PLEASE DOWNLOAD

This document is accessible on the **Kelty Mental Health, Pathways and Compass websites**. The aim of this toolkit is to provide a reference to primary care practitioners (PCPs) that promotes early recognition of eating disorders (EDs) and prevention of associated medical morbidity and mortality. In addition, it also aims to clarify the role of the PCP in working with, monitoring, and treating eating disorders in a shared care model. We strive for early diagnosis of EDs and connection to treatment in a patient/family-centered, safe, and compassionate manner.

## Please indicate reason for referral below:

☐ Assessment only ☐ Treatment

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# Referral Form – Child & Youth  Fax to 604-591-2302

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

**Date of Referral:** _____ **Referring Agent:** ☐ Hospital ☐ Pediatrician ☐ GP/Family Doctor

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

**Office Phone:** _____ **Fax:**_____

**Address:** _____

_____ _____
CITY POSTAL CODE

**PLEASE FILL OUT PAGE 4 "HOSPITAL/ SPECIALIST USE ONLY" FORM IF YOU ARE NOT THE PRIMARY CARE PROVIDER**

## 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*

Are parents/caregivers aware of referral? ☐ **Yes** ☐ **No**

**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**

**Parent Email Address:** _____ **Patient Email Address:** _____

**Parent/Caregiver 1 Name :**_____ **Contact #** _____

**Parent/Caregiver 2 Name:** _____ **Contact #**_____

**Primary Language:** _____ ☐ **Interpreter required:** _____
(Language)

## Eating Disorder Related Information:

**** PLEASE SEND GROWTH CHARTS****

Current Height: _____ in/cm Current Weight: _____ LBS/KG

Recent Wt. 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

**Eating Disorder-Related Behaviours:** (Frequency – D = Daily; W= Weekly; M = Monthly)

| | D | W | M | | D | W | M | | D | W | M |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ Restriction | ☐ | ☐ | ☐ | ☐ Laxatives | ☐ | ☐ | ☐ | ☐ Ipecac | ☐ | ☐ | ☐ |
| ☐ Bingeing | ☐ | ☐ | ☐ | ☐ Diuretics | ☐ | ☐ | ☐ | ☐ Diet Pills | ☐ | ☐ | ☐ |
| ☐ Vomiting | ☐ | ☐ | ☐ | ☐ Over-exercising | ☐ | ☐ | ☐ | ☐ Chewing & Spitting | ☐ | ☐ | ☐ |
| ☐ Insulin Misuse | ☐ | ☐ | ☐ | ☐ Diet Pills | ☐ | ☐ | ☐ | | | | |

☐ Suspect ARFID

☐ Other _____

**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:

**Psychiatric History: (See exclusion criteria)**

☐ Self harm ☐ Current suicidal ideation

☐ Past suicidal ideation and/or Attempt:
Date: _____

☐ Risk taking behaviours

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 ☐ BC Children's Hospital ED Program

☐ Mental Health Team Location & # _____

☐ Psychiatrist Name & # _____

☐ Psychologist/Therapist/Counsellor Name & #: _____

☐ Other Name & # _____

**Have you also made a referral to:**

☐ BC Children's Hospital ED Program ☐ Looking Glass Residence ☐ St. Paul's Hospital ED Program Date Referred:_____

☐ Any other psychiatric program? _____

## ** 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 (Landscape)

☐ I understand that the Fraser South 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.

☐ **If not the primary care physician:** I agree to identify and communicate the responsibility of continued medical monitoring to the primary care physician on page 4. (Signature is required)

_____ _____

**Referring/ Primary Care Provider's Signature** **Date**

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## HOSPITAL USE ONLY:

Please provide the name of the medical practitioner that will be overseeing client care upon discharge from hospital.

**Hospital Discharge Date:** _____

☐ Patient Discharge/ Treatment documents sent with referral package

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

**Physician's Name:** _____ _____ MSP: _____
**LAST NAME** **FIRST NAME**

**Office Phone:** _____ **Fax:**_____

**Address:** _____

_____ _____
**CITY** **POSTAL CODE**

☐ Primary care physician is aware of this referral and agrees to continue to medically follow this patient while client, remains on the South Fraser Eating Disorder program waitlist.

_____ _____
**Referring Care Provider's Signature** **Date**

☐ I understand that the Fraser South 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**

**ADDITIONAL RESOURCES FOR MEDICAL PROFFESIONALS**

Please visit www.aedweb.org under the resources > publications > medical care standards for the 2021 4th edition Guide to Medical Care.