Huron Perth Healthcare Alliance
Eating Disorders Outreach Program Referral Form

Information for Referral Source

- A referral from a Primary Care Provider (Physician or Nurse Practitioner) is ***required*** for the Huron Perth Healthcare Alliance (HPHA) Eating Disorders Outreach Program
- Individuals must have a Primary Care Provider who can provide metabolic monitoring
- Information marked "required" on the referral form must be completed in full
- Information requested on the referral form may be sent as a separate attachment if there is insufficient space on the referral form
- The referral source must inform whether subsequent referrals were made to similar programs to avoid duplication.

Note: if a referral needs to be cancelled for any reason, please contact Central Intake at 519-272-8210 extension 2570 or fax 519-272-8226.

Information for Individuals Being Referred

- The individual being referred must be aware that a referral is being made to the HPHA Eating Disorders Outreach Program.
- Appointment booking will be communicated via telephone to the client/caregiver and/or via fax to the referral source
- If an individual's contact information changes, they and/or their Substitute Decision Maker are responsible to notify the program or their Mental Health Clinician.
- HPHA's Central Intake staff will make three attempts to contact the individual by telephone. If contact cannot be made, the file will be closed and the referral source will be notified.
- Individuals can contact Outpatient Mental Health Services to receive an update on the status of their referral by calling Central Intake at 519-272-8210 extension 2570.

How to Submit the HPHA Eating Disorders Outreach Program Referral Form

- Fax the completed Referral Form to **519-272-8226** (each referral must be faxed separately)
- To help us provide the best care possible, please complete all pages of the referral form and include all relevant documents, such as previous psychiatric consultations, discharge summaries, medication administration records, psychological/mental health notes, lab and test results, and medical information.

Note: HPHA Central Intake will notify the Referral Source in writing that the referral forms are incomplete and/or illegible, and provide the Referral Status of Pending Due to Incomplete Documentation notification. The Referral Source will be asked to submit any missing information within **21 days** in order for the referral to be processed by Central Intake. If the required information is not received by this date, **the referral will be closed;** you are welcome to re-refer the individual in future. Re-referrals will be processed by the date that the completed package is received, **not the date of initial inquiry.**

If an individual is in crisis, direct them to the **Huron Perth Helpline and Crisis Response Team** at **1-888-829-7484** or their nearest Emergency Department. If an individual is experiencing an emergency, **9-1-1** should be contacted.

If you have any further questions or concerns, please contact Central Intake at 519-272-8210 extension 2570.

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Referral and Criteria Checklist – Required *(check all that apply)*

☐ 13 years of age and older
☐ Medically stable and has a Body Mass Index (BMI) of 16.5 or higher
☐ Has a Primary Care Provider (Physician or Nurse Practitioner) who can provide metabolic monitoring
☐ Resident of Perth County

Date of Referral: _____ *(DD/MM/YYYY)* Date Referral Received ***(office use only)***: _____

Is the client and/or Substitute Decision Maker/Caregiver aware of this referral: ☐ Yes ☐ No

Does the client and/or Substitute Decision Maker/Caregiver consent to this referral: ☐ Yes ☐ No

Please note, the client and/or Substitute Decision Maker/Caregiver must consent to a referral being made on their behalf to HPHA Outpatient Mental Health Services.

Client Demographic Information – Required *(please print)*

Client's Legal Name *(first name, last name)*: _____

Preferred Name *(if different from above)*: _____

Date of Birth *(DD/MM/YYYY)*: _____ Sex Assignment at Birth: ☐ Male ☐ Female ☐ Intersex

Gender Identity: _____ Pronouns: _____

Address: _____ ☐ No Fixed Address
(Street, Town, Province, Postal Code)

Telephone: _____ *(home/cell/work/other)*

Consent to contact by telephone: ☐ Yes ☐ No Consent to leave detailed voicemail: ☐ Yes ☐ No

Consent to speak with others in the household: ☐ Yes ☐ No

If yes, please specify *(name/relationship)*: _____

Household language: ☐ English ☐ French ☐ Other: _____

Custody Status *(Child & Adolescent 16 years of age and younger)*: _____

Living Arrangements *(self, spouse, parent(s), long-term care, group home, roommate(s) etc.)*: _____

_____

Client Health Card Information – Required

Health Card Number: _____ Version Code: _____

Additional Considerations

☐ Mobility ☐ Audio ☐ Visual ☐ Language ☐ Interpreter Services Required ☐ Service Animal

☐ Other: _____ If yes, please explain: _____

Child & Adolescent (13 – 17 Years of Age) - Required

Name of Substitute Decision Maker / Caregiver: _____

Relationship to Client: _____

Telephone: _____ *(home/cell/work/other)*

Consent to speak with Substitute Decision Maker / Caregiver regarding this referral: ☐ Yes ☐ No

Consent to leave the Substitute Decision Maker / Caregiver a detailed voicemail: ☐ Yes ☐ No

Consent to forward referral to London Health Sciences Centre for assessment: ☐ Yes ☐ No

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Substitute Decision Maker / Caregiver Information *(if applicable)*

By providing this information, the Referral Source confirms that the individual being referred consents for the HPHA to call the Substitute Decision Maker/Caregiver on their behalf. The HPHA will refrain from communicating Personal Health Information until consents are verified.

Name of Substitute Decision Maker / Caregiver: _____

Relationship to Client: _____

Telephone: _____ *(home/cell/work/other)*

Consent to leave detailed voicemail: ☐ Yes ☐ No

Referral Source Information - Required

HPHA requires the referring Primary Care Provider or the individuals Most Responsible Person to continue to be available for ongoing medical care

☐ Primary Care Provider ☐ Emergency Department Physician ☐ Hospitalist ☐ Psychiatrist

☐ Other: _____

Name: _____ FHT / Medical Clinic: _____

Address: _____

Telephone: _____ Fax: _____

Billing Number *(if applicable)*: _____ CPSO Number *(if applicable)*: _____

I will continue to provide medical care and ongoing follow-up to this client *(required):* ☐ Yes ☐ No

Presenting Concerns and Symptoms – Required *(attach if details cannot fit in the space provided)*

Please check all that apply and provide a brief narrative explaining presenting concerns and symptoms, including duration and frequency of symptoms, psychosocial factors, substance use issues and all other current and historical relevant information:

☐ Panic Attacks ☐ Unusual Speech/Behavior ☐ Delusions
☐ Fear/Paranoia ☐ Negative Symptoms ☐ Obsessions/Compulsions
☐ Hallucinations ☐ Thought Control
☐ Current substance abuse *(specify)*: _____
☐ Phobias *(specify)*: _____
☐ Other: _____

Comments: _____

_____

Medical/Physical Health – Required *(attach if details cannot fit in the space provided)*

Onset: _____

Precipitating Factors: _____

Client Condition: ☐ Refusal to Eat ☐ Type 1 Diabetes ☐ Pregnant ☐ Greater than 4 kg lost in last 30 Days

Diagnosis *(if known)*: ☐ Bulimia Nervosa ☐ Anorexia Nervosa ☐ Avoid/Restrictive Food Intake Disorder

☐ Binge Eating Disorder ☐ Other Eating Disorder: _____

Menstrual History: Menarche _____ Last menstrual period _____ ☐ Usual cycle

Has the client received previous treatment for Eating Disorders: ☐ Yes ☐ No

If yes, please specify: _____

Significant Family Illnesses (including Eating Disorders): ☐ Yes ☐ No

If yes, please specify: _____

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Medical Stability – Required

Please ensure information is within 90 days

				Date Taken
Weight	Current	Highest	Lowest	
Height				
Oral Temperature				
	Lying		Standing	
Blood Pressure				
Heart Rate				
Hydration	☐ Poor ☐ Fair ☐ Good ☐ Very Good			

Weight Control Methods - Required

		Per Day	Per Month
Food Restriction	☐ Yes ☐ No		
Excessive Exercise	☐ Yes ☐ No		
Binging	☐ Yes ☐ No		
Laxative Use	☐ Yes ☐ No		
Diuretics	☐ Yes ☐ No		
Vomiting	☐ Yes ☐ No		
Diet Pills	☐ Yes ☐ No		

_____

Name

_____ _____

Signature **Date** *(DD/MM/YYYY)*

Thank you for making a referral to the HPHA Eating Disorder Outreach Program. Your involvement in this client's care is important to us; if you have any questions or concerns, or wish to provide updated client information, please contact Central Intake at **519-272-8210 extension 2570** or **by fax 519-272-8226**