

one-Link Eating Disorders Referral Form:

Fax to 905-338-2878

(for Eating Disorder Programs at Halton Healthcare-OTMH and Trillium Health Partners-CVH)

Inquiries: Toll Free: 1-844-216-7411



CLIENT INFORMATION				OHIP #		
Last Name:				First Name:		
Date of Birth (D/M/Y)				Gender:		
Street Address:				City:		Prov.
Phone:				Can a message be left? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Alternate Contact Information:				Relationship:		
Name:						
Phone number:						
Preferred Language:						
Is an interpreter requested? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Barriers to Communication:						
<input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Sight Impairment <input type="checkbox"/> Other						
Is this referral from an Emergency Department Addictions or Mental Health Visit? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Is this referral from a Mental Health Inpatient unit? <input type="checkbox"/> No <input type="checkbox"/> Yes Specify hospital:						
<input type="checkbox"/> Please check if limited consent was obtained, and some information was withheld by the client						
Has this person previously received eating disorder treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Specify when and where:						
Current Weight:	Height:	BMI:	Lowest weight: Date:	Highest weight: Date:	HR: BP:	Date of last menstrual period:
Current Medications: (list or attach)						
Weight Control Methods		Frequency & Duration		Lab results **MANDATORY		
Food intake restrictions				<input type="checkbox"/> ECG <input type="checkbox"/> TSH		
Binge Eating				<input type="checkbox"/> Amylase <input type="checkbox"/> Na+, K, Ca2+		
Induced vomiting				<input type="checkbox"/> RBC Folate, vitamin B12 <input type="checkbox"/> Ferritin		
Laxative use				<input type="checkbox"/> Magnesium, Phosphate <input type="checkbox"/> Glucose		
Exercise Quantity (per week)				<input type="checkbox"/> Urea, Creatinine		
Chewing and Spitting				<input type="checkbox"/> CBC & Differential		
Diet Pills				<input type="checkbox"/> Albumin		
Diuretics				<input type="checkbox"/> FSH, LH, estradiol		
Substance Use				<input type="checkbox"/> AST, ALT, GGT, Alkaline Phosphatase, Bilirubin		
Other						
Referral Source Information: (affix sticker or stamp here)				Billing #:		
Professional Designation:				<i>*referrals can only be accepted from a Physician or NP</i>		
Office Address:						
Phone #:						
Fax #						

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