The Ottawa Hospital | L'Hôpital d'Ottawa

Adult Eating Disorders Program Referral for Assessment

Telephone: (613) 737-8010
Fax: (613) 737-8115

NOTE: Forms that are incomplete or not clearly printed will be returned

Date of Referral: _____

Referring MD/NP Name (Print):
_____ OHIP Billing No: _____

Primary Care Provider Name (Print):
_____ OHIP Billing No: _____

NOTE: PRIMARY CARE PROVIDER IS RESPONSIBLE FOR THE MEDICAL MONITORING OF THEIR PATIENT WHILE WAITING FOR ADMISSION AND POST DISCHARGE FROM THE EATING DISORDER PROGRAM.

*Suggested Medical Monitoring Guidelines attached.

❒ I have read and accept the medical monitoring guidelines

Signature of GP or NP: _____

Patient's Name (print): _____

Gender Identity: ❒Female ❒Male ❒Other

DOB: _____ (dd/mm/yy)

Address: _____

Health card Number: _____ Version Code: _____

Telephone Contacts:

Home: _____

Work: _____

Cell: _____

Leave messages of a confidential/medical nature:

❒Yes ❒No

❒Yes ❒No

❒Yes ❒No

Has the patient indicated specific concerns regarding confidentiality: ❒Yes ❒No
If yes, please clarify:
_____

Language(s): ❒ English ❒ French

❒ Other: _____

Name of other contact person: _____
Telephone Number: _____

Presenting Problems:

1) _____
2) _____
3) _____

Current Medications (include name, dose, route, frequency):

1) _____
2) _____
3) _____
4) _____

Eating Disorder Symptoms

Current Weight: _____ Height: _____BMI: _____

	NO	YES	FREQUENCY	
			# PER DAY	# PER WEEK
Food Restriction				
Binge Eating				
Induced Vomiting				
Laxatives				
Diet Pills				
Diuretics				
Excessive Exercise				

Associated Mental Health Issues:

Physical Exam / Positive Findings / Serum Electrolytes:

Substance Use:
❒ Alcohol ❒ Street drugs ❒ Prescription drugs
❒ Other: _____

List other Eating Disorder Programs/Mental Health Services you have currently referred the patient to: