BLUEWATER HEALTH

Health through partnership

Caring with kindness

Eating Disorder Adult Referral Form

Please read the following before completing. Incomplete referrals will be returned for completion.
Bluewater Health Eating Disorders program provides services to those residing in Lambton County.

We do not offer inpatient or hospitalization services. Please see below for intensive treatment options.

- Toronto General
- Ottawa Civic
- Credit Valley

If your client is in crisis, please direct them to their nearest emergency room, or contact a crisis service:

LAMBTON MENTAL HEALTH SERVICE CRISIS LINE (24/7): (519)-336-3445 or 1-800-307-4319
Distress Line: (519) 336-3000
Kids Help Phone: 1 (800) 668-6868 Text CONNECT to 686868
Sexual Assault Survivors Centre: (519) 337-3154 Or toll free 1(888) 231-0536
First Nations and Inuit Hope for Wellness Help Line: 1-855-242-3310
The Lesbian, Gay, Bi, Trans Youth Line : 1-800-286-9688 Text: 647-694-4275

Admission criteria:

- Able to access regular medical monitoring while in treatment and while awaiting treatment
- Willing and able to commit to staying alive and willing to address any life-threatening behaviors (this includes addressing eating disorder behaviors that put your life at risk)
- Additional diagnosis (depression, anxiety, PTSD, substance misuse etc.) may be important to address prior to entering eating disorder treatment (if patient has not done so already)
- Ready to work on recovering from the eating disorder
- If seeking youth treatment, guardian/family member for youth is willing and able to engage in family based treatment

Exclusion criteria:

- BMI less than 16.5 (if BMI < 16.5, please refer to above intensive treatment options)
- Acute suicidality or unmanaged psychosis
- Chronic medical condition that is untreated or unmanaged (such as diabetes, low blood pressure, electrolyte imbalance etc.)
- Cognitive or daily functioning impairments that would render someone unable to engage in treatment
- Substance dependence that requires withdrawal management first
- Currently in residential or day treatment; in hospital; or incarcerated
- ARFID (Avoidant/restrictive food intake disorder)

Referral to the program is for consultation and treatment recommendations. Treatment is not guaranteed and will be offered if appropriate. Bluewater Health Eating Disorder Outreach Program is not a fit for everyone.

Referral source information:

Referring Provider:
Primary Care Provider (PCP) Name:
PCP Address:
PCP Phone Number:
Are you the patient's primary care provider? ☐Yes ☐No

Does patient give consent for Bluewater Health Eating Disorder Outreach Program to speak to Primary Health Care Provider if not referring? ☐Yes ☐No

Your patient is aware you are making a referral to Bluewater Health Eating Disorder Outreach Program on their behalf? ☐Yes ☐No

Client information (fillable boxes):

First Name: Last Name:
Preferred Name: Date of Birth (Y-M-D):
Gender Identity: Address:
Phone Number: Permission to call? ☐Yes ☐No
Email: Permission to email? ☐Yes ☐No
Primary language: Is an interpreter required? ☐Yes ☐No
Current weight (lbs): Current height (inches):
BMI:
Weight History (any changes in weight over time; rapid weight loss or weight gain):

If known, please provide the following information about your patients disordered eating behaviours in the last 28 days to help triage:

Disorder Eating symptoms	**Per Day** (eg 3x per day)	**Per week**
Restricting food intake		
Binge Eating		
Induced vomiting		
Laxative use		
Diuretic use		
Diet pill use		
Exercise (to control weight)		
Chewing and Spitting food		
Fasting		
Other, please specify:		

Mental health history:

Medical history:

Is the patient pregnant? ☐Yes ☐No

If yes, how many weeks pregnant?

Is the client connected OR will be connected to the Bariatric Centre? ☐Yes ☐No

Allergies:

Risk factors

☐ Active Self Harm ☐Harm to others ☐Suicidal ideation or intent

☐History of suicidal behavior ☐Alcohol/Substance misuse ☐Inability to care for self

Additional comments:

Current Medications:

Medication	Dosage	Frequency	Is this a new medication?
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No

Do you feel this referral is of urgent nature? ☐Yes ☐No

If yes, please explain

_____

_____

Referring PCP/Clinician signature:

Date:

Thank you for your referral. Our staff will contact your patient directly as lengthy waitlist permits. If you require any further information, please do not hesitate to contact us.