QEII EATING DISORDER CLINIC PHYSICIAN REFERRAL FORM

PATIENT DATA:

Name:
Address: ____

____

Phone (H)____________________ (W) ________________

Birth date: ____

HCN: ____

Employed: Y _____ N _____

Occupation: ______________________________________

On Disability: ____________________________________

Marital Status: ___________________________________

REFERRAL PHYSICIAN DATA:

____

____

(W)

Completed Physical Exam : Y _____ N

Date Completed:

Report Included: Y _____ N

General Psychiatric Assessment Completed:
Y _____ N _____ Date Completed:
Report Included: Y _____ N

Diagnosis: ______________________________________

Reason for Referral:
History of Present Disorder:
Psychiatric History (Disorders (including drug or alcohol abuse, depression, suicide, self-abuse, psychosis), Rx given, Caregivers, Dates):
Medical History (including treatment and dates; Neuro, Respiratory, G.I., GU, Hearing, Endocrine, Musculoskeletal, Hemalogical, C.V.):

Past Surgeries:

Allergies (Food, Medication, Environmental) and associated reactions:

Blood work Completed: Y ______ N _____ Date Completed: _______________ Report Included: Y ______ N

CBC Diff. BUN CR AC glucose Electrolytes TSH EKG

Any test abnormalities noted? Y ______ N _____ Please identify:

Height: _______________Cm Weight: _________________Kg BP: _________________ P:

Current Medications (Prescriptions, Over-the Counter, Analgesics, Laxatives, Emetics, Vitamins, etc.):

DRUG	ROUTE	DAILY DOSAGE

Level of Motivation (Mark dash on line):

Does not see E.D. as problem/Denies E.D.	Ambivalent about treatment	Very Motivated wants E.D. gone

|____

Form of treatment requested: Inpatient: ____________ Outpatient: ____________ Uncertain:

Would any of these factors be problematic for the patient in order to attend treatment: (circle all that apply)

Work/school Financial limitation Child/family care Inability to function in a group Transportation

Other, please specify:

Please return to the QEII Eating Disorder Clinic, AJLMB, 5909 Veterans' Memorial Lane, Halifax, Nova Scotia, B3H 2E2 via mail or fax (902) 473-6282. Telephone inquiries: (902) 473-6288. Thank you for your referral.