Homewood
Health Centre

Eating Disorders Program

FOOD FOR THOUGHT

Consider this fact: In Canada one per cent of all women suffer with Anorexia Nervosa and two to four per cent have Bulimia Nervosa. One in every 10 people suffering with eating disorders is male.

Anorexia Nervosa is characterized by drastic weight loss (15 per cent of body weight or more) from dieting which can lead to emaciation and compromised physical and psychological health. Bulimia Nervosa consists of episodes of binge-eating followed by self-induced vomiting or purging with laxatives, diuretics, compulsive exercising, or periods of fasting. There are often fluctuations in body weight. Some people may present with symptoms of both disorders.

These disorders have serious medical and psychological complications and require professional attention and care.

RECOVERY PROCESS

Homewood Health Centre offers one of the largest in-patient eating disorders programs in Canada. Our program helps women and men aged 16 and older to regain control over their lives. This program helps patients:

- Take responsibility for their progress in the recovery process
- Restore healthy attitudes and eating habits
- Develop positive body image
- Learn about proper nutrition, exercise and other aspects of eating disorders
- Cope with emotional difficulties without self-defeating food and weight manipulation
- Increase self-awareness
- Develop and practise a range of healthy coping techniques
- Improve family/marital relationships
- Use best practice treatments, including Cognitive Behavioural Therapy and Dialectical Behaviour Therapy

PROGRAM PHILOSOPHY

This program has a voluntary, group-based, recovery-oriented approach, which encourages responsibility and healthy coping right from the start of treatment. Patients are immediately able to access a supportive community of peers and interdisciplinary staff who fully understand the complexities of the illness and the healing process. Program participants are provided with opportunities to practise their newly acquired coping skills with outings in the community (or at home, whenever practical), integrating their therapeutic experiences with those of "real life." While the program does not constitute a "cure" for eating disorders, it provides a strong foundation to build on through out-patient follow-up services in their home communities.

"I'm returning home a completely different person. I've learned skills to cope with my feelings in a more normal way and, for the first time in a long time, I finally feel alive!"

"A perfect balance of compassion and support, and action-focused recovery expectations. The first time I ever received help that provided me with any measure of success."

"To anyone entering this program I would say that you and only you are responsible for your recovery. It won't be handed to you; the opportunity is here - take advantage of it."

"Thanks to Homewood, I feel "human" again: I am connected to my feelings and hopeful, with the solid foundation to my recovery in place. I believe recovery is possible for everyone when the proper supports are in place during treatment. I have experienced many treatment modalities, programs and hospitalizations, and without a doubt or any exaggeration, I find Homewood's Program far ahead of even the next best."

Eating Disorders Program

Wherever possible, Homewood staff partner with out-patient supports to ensure the best possible continuity of care.

PROGRAM DESCRIPTION

The first phases of hospitalization include assessment and a preparation period, which will determine the patient's ability to engage in the program and to begin developing skills to manage symptoms. Establishing preliminary weight gain (where indicated) may require a period of medical stabilization/bedrest.

Each patient receives an individual collaborative recovery agreement. Patients with Bulimia Nervosa with minimal or no weight gain requirements will remain in hospital for approximately 10 to 12 weeks. Low-weight individuals will remain in hospital for a longer period. Those requiring weight gain are assisted through gradual restoration of normal eating behaviour, weight and a healthy exercise regimen.

ADMISSION CRITERIA

Admission to the Eating Disorders Program (EDP) is for individuals who:

- Are 16 years or older
- Have a diagnosis of Anorexia Nervosa, Bulimia Nervosa or EDNOS
- Are ready and willing to work in a group format
- Are motivated to come into the program
- Are willing to gain weight if recommended by the treatment team
- Are willing and able to eat solid foods
- Have normal blood work (Na, K, Cl and EKG) that is current within two weeks (abnormal blood work must be approved by a Homewood medical doctor)

OUT-PATIENT FOLLOW-UP SERVICES

Prior to discharge, we help patients develop out-patient contacts in their respective home communities.

FOR MORE INFORMATION

Additional program information is available on our website. For referral information, please contact our Admitting Department at 519.824.1010, ext. 2551. For clinical information, contact the Program Co-ordinator at 519.824.1010, ext. 2292.

"Coming to Homewood gave me the courage and motivation to believe in myself."

"I felt very nurtured and supported. I haven't had this feeling for many, many years. I loved it and it has helped me to learn and grow."

"I found all staff to be very approachable, understanding and supportive. Great teamwork! I feel privileged to have had this life-changing opportunity."

HOMEWOOD HEALTH CENTRE

150 Delhi Street, Guelph ON Canada N1E 6K9 • TEL 519.824.1010 FAX 519.824.8751

www.homewood.org

01/2014

Homewood
Health Centre

Homewood Improving Life | Health Centre de Santé

Date of Referral: _____

REFERRAL FORM FOR ADMISSION TO HOMEWOOD HEALTH CENTRE

PATIENT INFORMATION

Patient Name:		
Address:		
City:	Province/State:	Postal/Zip Code:
Country:	E-mail Address:	
Telephone:	Business/Mobile Phone:	
Date of Birth (YYYY-MM-DD):	Gender:	
Health Card #:		
Version Code:	Expiry Date:	
Department of National Defence Blue Cross Service # (if applicable):		
Veterans Affairs Canada K # (if applicable):		
Accommodation Requested: □ Ward □ Semi-private/Private □ Unknown		
Additional health insurance coverage? □ No □ Yes □ Unknown		

REFERRING CLINICIAN INFORMATION

Name:		
Your role: □ GP/FM Practitioner □ Psychiatrist □ Psychologist □ Therapist □ Nurse Practitioner □ Social Worker □ Counsellor □ EFAP □ Other: _____		
Address:		
City:	Province/State:	Postal/Zip Code:
Country:	E-mail Address:	
Telephone:	Fax:	
OHIP Billing # (if referred by a doctor):		
Are you referring as part of: □ WSIB □ DND □ VA □ Other Agency:		

In order to arrange a timely admission to the most appropriate program, please provide us with up-to-date information, dating back at least two years. Copies of past consults, test results and discharge summaries are most helpful.

Has this patient been admitted to Homewood before? □ No □ Yes

Reason for Referral:

Homewood Health Centre de Santé
Improving Life

Patient Name: _____

Please circle all the problems your patient has and underline their biggest problem:

Eating Disorder
Substance Abuse (drug and/or alcohol)
Addiction (drug and/or alcohol)
Chronic Pain
History of Abuse or Trauma
PTSD (post-traumatic stress disorder)
Self-Harm
Suicidality
Bipolar Disorder
Major Depression
Hypomania
Mania
Violence
Aggression
Dementia
Cognitive Disorder
(head injury, memory problems)
Social Phobia
Panic Disorders
OCD (Obsessive Compulsive Disorder)
ADHD (Attention Deficit Hyperactivity Disorder)
Personality Disorder
Schizophrenia
Acute Psychosis
(thought disorder/hallucination/delusion)
Chronic Psychosis
(thought disorder/hallucination/delusion)

SAFETY

Does the patient currently have suicidal ideation? □ No □ If Yes, do they have a plan? □ No □ Yes
Past suicidal behaviours? □ No □ If Yes, please explain in Safety Comments section below.
Date of last suicide attempt:
Is there a history of chronic self-injury? □ No □ If Yes, please explain in Safety Comments section below.
Is homicidal ideation present now? □ No □ If Yes, please describe in Safety Comments section below.
History of setting fires? □ No □ If Yes, please explain in Safety Comments section below.
Past criminal charges? □ No □ Unknown □ If Yes, please specify:
History of assault or violence? □ No □ If Yes, please specify:
SAFETY COMMENTS (e.g., describe method of suicide attempts or plans):

GROUP READY

Is the patient aware of this referral?	□ Yes	□ No
Is the patient motivated to engage in treatment?	□ Yes	□ No
Is the patient able to participate in a group-based program?	□ Yes	□ No
Is the patient able to reside on an unlocked unit?	□ Yes	□ No
Does the patient have a substitute decision maker?	□ Yes	□ No
Is the patient subject to a Community Treatment Order (CTO)?	□ Yes	□ No

CURRENT MEDICATIONS (psychiatric and other, e.g., insulin. Please attach a list if necessary.)

Name	Dosage	Frequency	Reason for Use

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Patient Name: _____

MEDICAL INFORMATION (Please attach a list if necessary.)

Physical health/conditions:
Any physical limitations or special needs? □ No □ If Yes, please describe:
Please identify any of the following that may apply to this patient: *limited vision or hearing, learning disabilities, intellectual or developmental disabilities, cognitive or memory problems, speech or language impairment, language barriers, does not speak English, etc.*
Is the patient able to walk, feed, dress, bathe and care for self? □ Yes □ If No, please describe:
Physical nursing care required? □ No □ If Yes, please describe:
Does the patient suffer from Chronic Pain? □ No □ If Yes, is it stable? □ No □ Yes
Is the pain managed by narcotics? □ No □ If Yes, please provide dosage and frequency on Page 2 of this form.

Current Height:	Current Weight:

Please indicate if the patient has tested positive for any of the following infections:

□ C-Difficile □ Hepatitis □ HIV □ MRSA □ VRE □ Other:

Comments:

Has the patient had any psychiatric and/or medical hospitalizations within the last five years?
□ No □ If Yes, where, when and why?

Please forward discharge notes or consults from hospital stays.

Is the patient currently in a hospital? □ No □ If Yes, where? _____	
Admission date:	Projected discharge date:
Reason for current admission:	
Duration of current episode:	

Homewood Health Centre de Santé
Improving Life

Patient Name: _____

ADDICTION

Does the patient currently have any drug or alcohol issues? □ No □ Yes
If yes, substance(s) of choice: _____ □ Oral □ Smoked □ Snorted □ IV
Length of consumption: Amount consumed per day:
Has the patient ever experienced severe withdrawal symptoms from alcohol or drugs (e.g., DTs, seizures or hallucinations)? □ No □ If Yes, describe:
Is the patient currently detoxified? □ No □ Yes
Last use of alcohol: Last drug use:
What losses has the patient suffered due to their addictive behaviour? (i.e., relationships, job, legal, financial losses)
Does the patient admit to having a problem? □ No □ Yes

METHADONE OR SUBOXONE USE ***(note: some programs have specific admission requirements concerning methadone treatment.)***

Is the patient currently being prescribed Methadone or Suboxone as a treatment for addiction or pain? □ No □ If Yes, please indicate current dose and length of time on that dose:
Name and contact information of Physician prescribing Methadone or Suboxone (if applicable):
Is the patient willing to taper off Methadone or Suboxone, if necessary? □ No □ Yes
Is the patient using medical marijuana? □ No □ Yes

If you are referring to the **Eating Disorders Program**, medical and lab requests will be forwarded to the patient. The forms are to be completed by your patient's Medical Doctor and forwarded to Admitting as soon as possible. The patient must reduce/stop laxatives and diet pills, etc., with medical support in community.

If you are referring to the **Program for Traumatic Stress Recovery**, please indicate the type of trauma the patient experienced: □ Childhood □ Adult domestic □ Occupational □ Accident-related □ Other: _____
Please list patient's current trauma-related symptoms:

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Patient Name: _____

PLANNING FOR FOLLOW-UP

Does the patient have an address to return to? □ No □ Yes		
Name of patient's Family Physician (if not listed above):		
Address:		
City:	Province/State:	Postal/Zip Code:
Country:	E-mail Address:	
Telephone:	Fax:	
Length of time providing care for this individual:		
Will the above Family Physician be providing follow-up care? □ Yes □ If No, please provide contact information for the Physician providing follow-up care, including **name**, **address**, **phone number, fax number** and **email address**:		

ALTERNATE FOLLOW-UP CONTACT INFORMATION

Name:		
Role: □ Psychiatrist □ Therapist □ EFAP □ Case Manager □ Social Worker □ Nurse Practitioner □ Health Authority □ Other: _____		
Address:		
City:	Province/State:	Postal/Zip Code:
Country:	E-mail Address:	
Telephone:	Fax:	
Length of time providing care for this individual:		

Additional comments (i.e., your goals/your patient's goals for this admission):

How did you hear about Homewood?
□ Patient request □ Past referral □ Social Media □ Conference □ Brochure □ Direct Mail Package
□ Health Professional □ Website □ Other

Thank you for your referral to Homewood Health Centre. In order to confirm this referral, please advise your patient to complete and submit the **Patient Information Form** (available online at www.homewood.org).

All forms and copies of past records and reports should be sent as soon as possible to:
Admission Department, Homewood Health Centre
150 Delhi Street, Guelph ON N1E 6K9
PH: 519.767.3550 • T/F: 866.839.2594 • FX: 519.767.3533 • EM : admit@homewood.org

We will contact you once a decision has been made regarding your patient's admission. If you have any questions, please contact our Admitting Case Manager's office at 519.767.3550. We are available Monday through Friday (holidays excepted) from 8:30 AM to 9:00 PM EST.

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PATIENT INFORMATION FORM

You have been referred for admission to Homewood Health Centre. To prepare for your arrival, we need some information from you. If you are unable to complete this form by yourself, you can ask a friend or relative to help you complete it, or you may phone Homewood's Admitting Department for assistance.

Please complete this form in black ink and return it to: **Admitting Department**
150 Delhi Street, Guelph ON N1E 6K9
Fax: 519.767.3533 **Email:** admit@homewood.org
Phone: 519.767.3550

PATIENT CONTACT INFORMATION (please provide telephone number(s) where messages can be left)

Title: _____ Last Name: _____ Given Name: _____

Preferred Name: _____ Middle Name: _____ Alias: _____

Maiden Name: _____ Mother's Maiden Name: _____ Gender: _____

Address: _____ ❑ Transient

City: _____ Province/State: _____ Postal/Zip Code: _____ Country: _____

Phone: _____ Business Phone: _____ Ext: _____ Mobile phone: _____

Email: _____ Date of Birth: _____

Preferred method of contact: ❑ Phone ❑ Email

Health card number: _____ Version code: _____ Issuing Province: _____

Health card name (if different from above): _____ OR reason for no HC#: _____

EMERGENCY CONTACT INFORMATION (please provide telephone number(s) where messages can be left)

Name: _____ Relationship to Patient: _____

Address (if different from above): _____ City: _____

Province/State: _____ Postal/Zip Code: _____ Country: _____

Phone: _____ Business/Alternate Phone: _____ Email: _____

SECOND EMERGENCY CONTACT INFORMATION (please provide telephone number(s) where messages can be left)

Name: _____ Relationship to Patient: _____

Address (if different from above): _____ City: _____

Province/State: _____ Postal/Zip Code: _____ Country: _____

Phone: _____ Business/Alternate Phone: _____ Email: _____

REFERRAL SOURCE CONTACT INFORMATON

Name of Referring Physician or Clinician: _____

Name of Disability Case Worker: _____

Family Physician: _____ Address: _____

Phone: _____

What type of accommodation are you requesting? ❑ Ward ❑ Semi-Private ❑ Private

Reason for admission: _____

PATIENT INFORMATION

Do you have a history of setting fires? ❑ Yes ❑ No

Are you currently involved in a clinical drug study/trial? ❑ Yes ❑ No If Yes, explain: _____

Are you aware that some programs require supervised urine testing (as per program policies)? ❑ Yes ❑ No

Are you coming for treatment because of a court order? ❑ Yes ❑ No

Will you be bringing your vehicle for paid parking? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No

Please list any allergies (e.g., medication, foods, insects): _____

_____

Marital Status: ❑ Single (never married) ❑ Married ❑ Common Law ❑ Divorced ❑ Separated ❑ Widowed

With whom are you currently living? _____

Do you have children? ❑ Yes ❑ No If Yes, please complete the following:

Name	Age	Quality of Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Education:
❑ College (completed) ❑ University (BA Level) ❑ University (MA, PhD)
❑ University/College (partial) ❑ Secondary (completed) ❑ Secondary (partial)
❑ Technical/Trade school ❑ Elementary (grade 8 or less) ❑ Unknown

Employment status:
❑ Full-time employment ❑ Part-time employment ❑ Employment Insurance
❑ Retired ❑ Disability assistance (private) ❑ Homemaker
❑ Student/Retraining ❑ Unemployed seeking work ❑ Unemployed not seeking work
❑ Ont. Disability Support Prgm (ODSP) ❑ Guaranteed Income (pensions) ❑ Unknown Financial Status
❑ Family support/inheritance ❑ Social Assistance ❑ Other (investment/student loan)
❑ Disabled ❑ No income ❑ Other

If you are not working, when were you last employed? _____

Occupation: _____ Employer: _____

Employer's Address: _____ Phone: _____

Source of income: ❑ Employed ❑ Social assistance ❑ Other income ❑ No income ❑ Employment Insurance ❑ Pension
❑ Disability Insurance

Height: _____ Weight: _____ Are you of Aboriginal Origin? ❑ Yes ❑ No ❑ Unknown

Are you fluent in English ❑ Yes ❑ No ❑ Other preferred language: _____

Do you have difficulty reading? ❑ Yes ❑ No Do you have difficulty writing? ❑ Yes ❑ No

Please indicate any religious beliefs or practices that may affect your treatment: _____

Do you smoke? ❑ Yes ❑ No

Have you ever received a pneumonia vaccination? ❑ Yes ❑ No If Yes, please provide date (YYYY-MM-DD): _____

Date of last flu shot (YYYY-MM-DD): _____

Do you have any history of self-harm (cutting, burning, etc.)? ❑ Yes ❑ No Past suicide attempts? ❑ Yes ❑ No

Additional comments: _____

_____

_____

PROSTHETICS/MOBILITY

❑ Prosthetic leg
❑ Prosthetic arm
❑ Lower Denture
❑ Upper Denture
❑ Partial Bridge
❑ Other needs _____

❑ Glasses
❑ Contacts
❑ Hearing problems
❑ Hearing aids
❑ CPAP machine

❑ No problem walking
❑ Mobility aids (wheelchair, cane, walker, scooter, crutches)
❑ Transfer assistance needed
❑ Vision problems

Do you require a service animal? ❑ Yes ❑ No

DISCHARGE PLANNING

After discharge, would you have concerns about any of the following? (Check all that apply.)

❑ Child care issues ❑ Personal safety ❑ Crisis support ❑ Support for activities of daily living

PRIOR ADMISSIONS, CURRENT OUT-PATIENT SERVICES, ACTIVE SELF-HELP GROUPS

Please list any admissions to Homewood and/or other psychiatric or addiction facilities:

Year admitted: _____ Facility: _____ Length of Stay: _____

Year admitted: _____ Facility: _____ Length of Stay: _____

Year admitted: _____ Facility: _____ Length of Stay: _____

Year admitted: _____ Facility: _____ Length of Stay: _____

Number of admissions to Homewood: _____ Number of admissions to other facilities: _____

Are you currently using any out-patient services? ❑ Yes ❑ No If Yes, please provide details:

Name of Service: _____

Contact: _____ Telephone: _____

Name of Service: _____

Contact: _____ Telephone: _____

Name of Service: _____

Contact: _____ Telephone: _____

Are you currently participating in any self-help groups? ❑ Yes ❑ No If Yes, please list: _____

_____

PHARMACY INFORMATION

Pharmacy Name: _____ Address: _____

City: _____ Province/State: _____ Postal/Zip Code: _____

Country: _____ Phone: _____

Have you used another pharmacy in the last year? ❑ Yes ❑ No ❑ Unknown

DRUG PLAN INFORMATION

Do you have a drug plan? ❑ Yes ❑ No If No, how do you currently pay for drugs? _____

Please note: for ODSP, Trillium and other Ontario Government social service programs, there is an online list that your Homewood doctor can consult to ensure the prescribed medications are covered.

BILLING

If you are requesting semi-private or private accommodation, please complete this section:

Are you self-paying for your accommodation? ❑ Yes ❑ No

If you are self-paying (in part or in whole), please indicate the method of payment:

❑ Cash ❑ Major Credit Card ❑ Cheque

If you are not self-paying, please provide the following information:

Name of Payer: _____ Address: _____

City: _____ Province/State: _____ Postal/Zip Code: _____

Country: _____ Phone: _____

Please note: *30 days' payment is due on the date of admission. Please refer to financial information provided by the Admitting Department.*

INSURANCE INFORMATION ***(Note: an employee number is mandatory for all Chrysler Corporation patients requesting payment through insurance)***

Primary Insurer:

Name of Insurance Company: _____ Employee Number: _____

Group Policy Number: _____ I.D. or Certificate Number: _____

Subscriber's Name: _____ Subscriber's Date of Birth (YYYY-MM-DD): _____

Subscriber's Employer: _____ Employer's Phone Number: _____

Employer's Address (if different from above): _____ City: _____

Province/State: _____ Postal/Zip Code: _____ Country: _____

Patient's Relationship to Policy Holder: ❑ Holder ❑ Spouse ❑ Dependant ❑ Student (full-time) ❑ Student (part-time)

Secondary Insurer:

Name of Insurance Company: _____ Employee Number: _____

Group Policy Number: _____ I.D. or Certificate Number: _____

Subscriber's Name: _____ Subscriber's Date of Birth (YYYY-MM-DD): _____

Subscriber's Employer: _____ Employer's Phone Number: _____

Employer's Address (if different from above): _____ City: _____

Province/State: _____ Postal/Zip Code: _____ Country: _____

Patient's Relationship to Policy Holder: ❑ Holder ❑ Spouse ❑ Dependant ❑ Student (full-time) ❑ Student (part-time)

Although you may have semi-private or private coverage, you should be aware that some insurance companies do not cover accommodation at Homewood Health Centre Inc. To avoid unexpected charges, we strongly suggest that you obtain written verification that your insurance company will cover the cost of your stay at Homewood prior to admission. Please note: you are responsible for payment of your semi-private or private accommodation if your insurance company does not cover the cost.

Please ask your insurance company the following questions:

1. *Does my insurance cover the cost of semi-private or private accommodation for mental illness/addiction treatment at Homewood Health Centre Inc.?*
2. *What is the maximum amount of money or maximum length of stay covered by my insurance?*

Our practice with some insurance companies is to email information for verification. Please contact us if you are not in agreement with this process. Please sign below authorizing Homewood to verify the accuracy of the above insurance information with your insurance company and/or employer (Note: when verifying this information with the insurance company, it may be necessary to share the reason for admission.)

Name of Employer: _____ Name of Insurance Company: _____

Signature: _____ Date: _____

Homewood is compliant with current privacy legislation. Homewood collects personal information for assessment and treatment, as well as for operational and organizational, research and teaching, and legal and regulatory purposes. For questions or concerns contact the Privacy Officer at privacy@homewood.org or 519.824.1010, extension 2443.

Homewood | Health Centre de Santé

Re: Admission to Homewood Eating Disorders Program

Dear Referral Source:

We have received a referral to the Eating Disorders Program on behalf of your patient/client. To complete this process, we require the following information:

1. An **Eating Disorders Program Preadmission Assessment Information Form**, completed by yourself (i.e., referral source.)
2. Your patient's/client's **results of sTSH, GGT, CBC, Electrolytes, Calcium, Magnesium**.
3. Your patient's/client's **results of a recent ECG**.
4. A **Patient Information Form,** completed by your patient/client (if not already submitted).
5. An **Eating Disorders Program Questionnaire**, completed by your patient/client.

Please return the above information to our office as soon as possible. If you wish to fax this information, please use our confidential fax number, which is 519-767-3533.

If you have any questions, please contact the Admitting Department at 519-767-3550.

Thank you,

Admitting Department
Homewood Health Centre

#03033
revised 04-2014

Homewood Health Centre Inc.
150 Delhi Street, Guelph, Ontario, Canada N1E 6K9 T 519.824.1010 F 519.767.3533 **homewood.org**

Homewood Health Centre Inc.
Specialized Psychiatry Division

TO BE COMPLETED BY FAMILY PHYSICIAN AND FAXED TO:
ADMITTING DEPARTMENT 519-767-3533 (Please use black ink.)

EATING DISORDERS PROGRAM ASSESSMENT FORM

1. PATIENT'S NAME _____ Height ft/in:_____ Weight: lbs_____

Name of Patient's Physician: _____

2. CHIEF COMPLAINT AND HISTORY OF PRESENTING ILLNESS:

_____

_____

_____

3. CURRENT MEDICATIONS:

NAME	DOSE	NAME	DOSE	NAME	DOSE

b) Any concerns re: abuse of prescription drugs or over-the-counter medications? _____

_____

4. PSYCHIATRIC HISTORY:		**PAST**	**PRESENT**	**NOT APPLICABLE**	
4.1	Hospital Admission	☐	☐	☐	Where/When/Reason
4.2	Out-patient Program	☐	☐	☐	Where/When/Reason
4.3	Suicidal Behaviour	☐	☐	☐	
4.4	Aggressive Behaviour	☐	☐	☐	
4.5	Substance Abuse	☐	☐	☐	
4.6	Legal Involvement	☐	☐	☐	
4.7	Abuse:				
	I) Physical	☐	☐	☐	
	II) Emotional	☐	☐	☐	
	III) Sexual	☐	☐	☐	

Name of Patient: _____

5. LABORATORY INVESTIGATIONS:

The following are mandatory tests required - please provide results.

sTSH _____ CBC _____ Electrolytes _____

Blood Glucose _____ BUN _____ Creatinine _____

Urinalysis _____ ECG (please provide interpretation)

(Please provide any other tests results you have available on this patient.)

6. PHYSICAL ASSESSMENT:

a) Past Medical History

Major Illness: _____

Major Surgery: _____

Head Injury: _____

Seizures: _____

Hepatitis: _____

HIV: _____

Cardiac Arrhythmia: _____

Hypokalemia: _____

GI Complications: _____

Other: _____

b) Present Physical Condition	**Normal**	**Abnormal**
Blood Pressure	☐	☐
Heart Rate	☐	☐
Respiratory	☐	☐
Neurological	☐	☐
Cardiovascular	☐	☐
Gastrointestinal	☐	☐
Genitourinary	☐	☐
Hearing/Sight	☐	☐
Musculoskeletal (i.e., osteoporosis)	☐	☐
Endocrine (i.e., diabetes, thyroid)	☐	☐
Dermatology	☐	☐
L.M.P.	☐	☐
Menopause	☐	☐
Ob/Gyn (i.e., pregnancy, STDs)	☐	☐

Name of Patient: _____

7. PHYSICAL HEALTH

Has your patient ever had any of the following symptoms **related to his/her eating disorder**?

	Yes	Duration
Fainting	☐	_____
Seizures	☐	_____
Blood in vomitus	☐	_____
Edema (swelling)	☐	_____
Missed menstrual periods	☐	_____

8. *__ADDITIONAL COMMENTS__: (Please explain any abnormal findings.)

_____
_____
_____
_____
_____

Date: _____ Signature: _____

Homewood Health Centre Inc.
Specialized Psychiatry Division
Eating Disorders Program Questionnaire **Name:** _____

TO BE COMPLETED BY THE PATIENT (Please use black ink.)

EATING DISORDERS PROGRAM QUESTIONNAIRE

Please note: This questionnaire must be completely filled out and returned to **the Admitting Department - Specialized Psychiatry Division**, Homewood Health Centre, before we can confirm your suitability for the program. All information will be kept strictly confidential**.**

IDENTIFYING INFORMATION

Date: _____ Name: _____
First Middle Last

EATING DISORDER HISTORY

1. Current Weight: _____ lbs. 2. Current Height: _____ ft./in.

3. Desired Weight: _____ lbs. 4. Highest Past Weight: _____ lbs. Age at time: _____

5. Lowest Past Weight (since age 16): _____ lbs. Age at time: _____

6. At your current weight, do you feel that you are:

extremely thin	somewhat thin	normal weight	moderately overweight	extremely overweight
↑	↑	↑	↑	↑

7. During the past three months, which of the following behaviour have you engaged in?

		YES	NO
a.	Restricting calorie intake	☐	☐
b.	Avoiding carbohydrates	☐	☐
c.	Avoiding fat in food	☐	☐
d.	Fasting	☐	☐
e.	Chewing and spitting out food	☐	☐
f.	Binge eating (feeling out of control while eating)	☐	☐
g.	Vomiting (after eating)	☐	☐
h.	Exercise to control weight - describe type and time spent _____	☐	☐
i.	Exercise to cope with emotions - describe type & time spent _____	☐	☐
j.	Exercise that is difficult to stop - describe type & time spent _____	☐	☐
k.	Use of diet pills (name of pill/amount per day_____)	☐	☐
l.	Laxative use (for weight control), including laxative/cleansing teas (name of pill, amount per day_____)	☐	☐
m.	Use of diuretics	☐	☐
n.	Use of enemas	☐	☐
o.	Use of Ipecac	☐	☐
p.	Fluid loading to numb hunger (i.e. water, diet drinks, coffee, tea)	☐	☐
q.	Thinking a lot about food, weight, or exercise (please underline all that apply)	☐	☐
r.	Being fearful about gaining weight	☐	☐

8. Do you have problems with anxiety or depression? Please describe. _____

_____

9. At the present time, are there any factors that could interfere with you fully participating in this group-based program?

_____

ALCOHOL AND DRUG USE

1. Please specify the amount of alcohol consumed in an average week, including a weekend. What do you drink? Do you drink alone, or socially?

_____

2. If you are presently using street drugs, please specify type, amount, and current usage pattern.

_____

3. If you are presently abusing prescription drugs, please specify type, amount, and current usage pattern.

_____

4. Do you or anyone who knows you think you might have an alcohol or drug problem?

_____

5. The Eating Disorders Program has a zero tolerance policy for drug and alcohol use while in the program. Do you anticipate any problems being abstinent?

_____

RELATIONSHIP HISTORY

1. Current Living Arrangement:

 alone with parents dorm or shared accommodation
 married or cohabitating single with children (please list their ages) _____

2. What do you consider to be possible factors contributing to your eating disorder (e.g., family or relationship difficulties, environmental stresses, life changes, media influences, psychological issues, etc.)?

_____

_____

_____

3. Please list any relatives who have suffered from an eating disorder, depression, alcohol abuse, or other emotional problems.

_____
_____

If an eating disorder, please specify, including present condition and treatment:

_____
_____
_____

TREATMENT HISTORY

1. Please describe any treatments attempted for your eating disorder, including the names of hospitals, professionals seen, and dates of contacts. Which treatments have been the most effective? Least effective?

_____

_____

_____

_____

2. Please describe any treatment for any other psychological issues, including previous medications.

_____

_____

_____

TREATMENT GOALS

1. Please specify what goals you would like to work towards in an in-patient treatment setting.

_____

_____

_____

_____

Date: _____ Patient Signature: _____

If you have any questions regarding this form, please contact April Gates, Program Co-ordinator, Eating Disorders Program at 519-824-1010, extension 2292.

Please return the completed questionnaire to:

Admitting Department - Specialized Psychiatry Division
Homewood Health Centre
150 Delhi Street
Guelph, ON N1E 6K9