

Eating Disorders Program



Homewood Health Centre offers the largest inpatient eating disorders program in Canada. Our program helps all genders, aged 16 and older, regain control over their lives.

Our program helps patients:

- Develop/restore healthy attitudes and eating habits
- 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 practice a range of healthy coping techniques
- Take responsibility for their progress in the recovery process
- Improve family/marital relationships
- Use best practice treatments including Cognitive Behavioural Therapy and Dialectical Behaviour Therapy

Program Philosophy

Homewood's Eating Disorders Program consists of 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 inter-professional staff who fully understand the complexities of the illness and the healing process. Program participants are provided with opportunities to practice their newly acquired coping skills with outings in the community (or at home, when practical) and by integrating their therapeutic experiences with those of 'real life'. Our program provides a strong foundation to build on when patients return to their home communities.

For More Information

Please contact the Director of Operations at 519.824.1010 ext. 2420 or eatingdisorders@homewoodhealth.com

homewoodhealth.com



Homewood
Health | Santé

Eating Disorders Program

Program Description

The assessment and preparation phases of the program will assist in determining 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.

After the assessment phase of the program each patient will receive an individual collaborative recovery agreement. Patients with Bulimia Nervosa, with minimal or no weight restoration requirements, will stay at Homewood for a minimum of 12 weeks, or longer. Low-weight individuals will stay for a longer period. Patients who require weight restoration will be assisted with normal eating behaviours, weight, and a healthy exercise regimen.

Admission Criteria

Admission to the Eating Disorders Program is for individuals who:

- Are 16 years of age or older
- Have a diagnosis of Anorexia Nervosa or Bulimia Nervosa
- 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 lab results (Na, K, and EKG) that is current (within four weeks) (*abnormal findings must be reviewed by a Homewood physician for approval and acceptance into Eating Disorders Program*)

Outpatient Follow-up Services

Prior to discharge we will assist patients in developing outpatient contacts in their respective home communities.

For More Information

Please contact the Director of Operations at 519.824.1010 ext. 2420 or eatingdisorders@homewoodhealth.com.

3%

of females suffer from an eating disorder in their lifetime

"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!"



1 in 10 people suffering from an eating disorder is male

"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."

"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 St., Guelph ON N1E 6K9

Telephone: 519.824.1010 | Fax: 519.824.8751

homewoodhealth.com



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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: <input type="checkbox"/> Ward <input type="checkbox"/> Semi-private/Private <input type="checkbox"/> Unknown		
Additional health insurance coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		

REFERRING CLINICIAN INFORMATION

Name:		
Your role: <input type="checkbox"/> GP/FM Practitioner <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Psychologist <input type="checkbox"/> Therapist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Social Worker <input type="checkbox"/> Counsellor <input type="checkbox"/> EFAP <input type="checkbox"/> 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: <input type="checkbox"/> WSIB <input type="checkbox"/> DND <input type="checkbox"/> VA <input type="checkbox"/> 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:



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

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

SAFETY

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

GROUP READY

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

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

Name	Dosage	Frequency	Reason for Use



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:

ADDICTION

Does the patient currently have any drug or alcohol issues? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, substance(s) of choice: _____ <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Snorted <input type="checkbox"/> 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)? <input type="checkbox"/> No <input type="checkbox"/> If Yes, describe:	
Is the patient currently detoxified? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes
Is the patient using medical marijuana? <input type="checkbox"/> No <input type="checkbox"/> 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 <u>Program for Traumatic Stress Recovery</u> , please indicate the type of trauma the patient experienced: <input type="checkbox"/> Childhood <input type="checkbox"/> Adult domestic <input type="checkbox"/> Occupational <input type="checkbox"/> Accident-related <input type="checkbox"/> Other: _____
Please list patient's current trauma-related symptoms:



Patient Name: _____

PLANNING FOR FOLLOW-UP

Does the patient have an address to return to? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Therapist <input type="checkbox"/> EFAP <input type="checkbox"/> Case Manager <input type="checkbox"/> Social Worker <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Health Authority <input type="checkbox"/> 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.homewoodhealth.com).

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@homewoodhealth.com



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@homewoodhealth.com
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 INFORMATION

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? First Nation Inuit Métis Not Aboriginal
 Unknown Not Applicable

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Prosthetic leg | <input type="checkbox"/> Glasses | <input type="checkbox"/> No problem walking |
| <input type="checkbox"/> Prosthetic arm | <input type="checkbox"/> Contacts | <input type="checkbox"/> Mobility aids (wheelchair, cane, walker, scooter, crutches) |
| <input type="checkbox"/> Lower Denture | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Transfer assistance needed |
| <input type="checkbox"/> Upper Denture | <input type="checkbox"/> Hearing aids | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Partial Bridge | <input type="checkbox"/> CPAP machine | |
| <input type="checkbox"/> Other needs _____ | | |

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 Office at privacy@homewoodhealth.com or 519.824.1010, extension 2443.



Re: Admission to Homewood Eating Disorders Program

Dear Healthcare Professional:

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, Calcium, Magnesium and Sodium/Potassium/Chloride** levels.
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



A part of **Homewood Health Inc.**TM

150 Delhi Street, Guelph, Ontario, Canada N1E 6K9 T 519.824.1010 F 519.824.8751

homewood.org

**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

Homewood Health Centre
 Specialized Psychiatry Division
Eating Disorders Program Assessment Form

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	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rate	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
Hearing/Sight	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal (i.e., osteoporosis)	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine (i.e., diabetes, thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
Dermatology	<input type="checkbox"/>	<input type="checkbox"/>
L.M.P.	<input type="checkbox"/>	<input type="checkbox"/>
Menopause	<input type="checkbox"/>	<input type="checkbox"/>
Ob/Gyn (i.e., pregnancy, STDs)	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	_____
Blood in vomitus	<input type="checkbox"/>	_____
Edema (swelling)	<input type="checkbox"/>	_____
Missed menstrual periods	<input type="checkbox"/>	_____

8. *ADDITIONAL COMMENTS: (Please explain any abnormal findings.)

Date: _____ Signature: _____

Eating Disorders Program Questionnaire **Name:** _____

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:

Eating Disorders Program Questionnaire **Name:** _____

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**