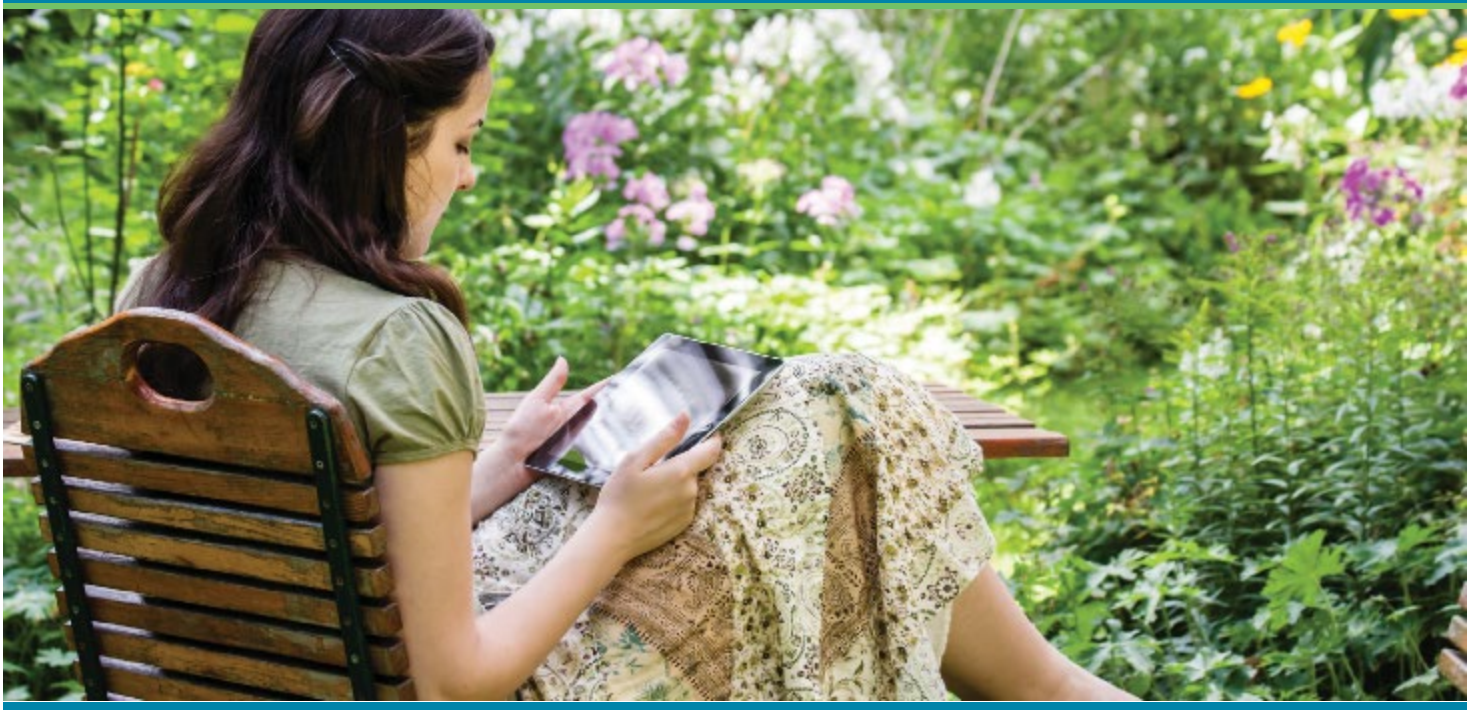
Eating Disorders Program (EDP)



As Canada's largest inpatient Eating Disorders Program, we provide evidence-based, personalized treatment while expertly addressing concurrent issues including trauma and addiction.

With a focus on normalization of eating and activity, and interruption of eating disorder symptoms, patients are able to create a life with meaning, and receive care in a community of peers and professionals who fully understand the complexities of eating disorders and the process of recovery.

Family members may be included in treatment, and/or recovery management plans.

Our program helps patients:

- Develop and restore healthy attitudes and eatinghabits
- Learn about balanced nutrition, physical activity, andother aspects of eating disorders
- Cope in healthy ways with emotional difficulties
- Develop and practice a range of healthy copingtechniques
- Increase self-awareness
- Improve family, marital and personal relationships
- Take responsibility for their progress in the recoveryprocess

> "A perfect balance of compassion, support and action- focused recovery expectations. For the first time ever, I've received help that provided me with success."
>
> - Program Patient

For more information about our program, contact us at:
admit@homewoodhealth.com Homewood Health Centre 150 Delhi St.,
Guelph ON N1E 6K9 **Telephone:** 1-866-839-2594 or 519-824-1010 ext 32551
Fax: 519-767-3533

Treatment For:	Individuals of all genders 16+ years of age who meet DMS-V criteria for: • Anorexia Nervosa • Bulimia Nervosa • Other Specified Feeding or Eating Disorders
Program Length:	Programs focus on stabilization, normalization of eating and symptom interruption, weight restoration (if required), followed by skills application and community reintegration. Two streams include: • Core Skills Stream (9 weeks) • Restoration Stream (16 weeks)
Treatment Involves:	• Cognitive Behavioural Therapy • Dialectical Behavioural Therapy elements • Motivational Enhancement • Nutrition Counselling • Pharmacotherapy • Interpersonal Therapy, Art, Music, Horticulture and Recreation Therapies
Delivery:	Primarily group based
Other:	An Eating Disorders Program referral form must be completed when referring into the program, in addition to the regular referral form. For more information please contact: admit@home-woodhealth.com

Our Approach to Care

As one of the most intractable mental health illnesses, eating disorders require an intensive, structured, and supervised approach to care. EDP fulfills a unique niche in Canada by providing treatment for those whose eating disorder is severe enough that it cannot be managed on an outpatient basis, but is not so severe that they require medical management in a general hospital setting.

EDP Core Skills (9 weeks) and Restoration (16 weeks) Streams

These flexible 9 and 16 week inpatient streams are designed to support people with moderate to severe eating disorders who may require weight restoration and/or for whom intensive and daily monitoring is required. We focus on teaching new coping skills and improving health through stabilization and symptom interruption, enhanced therapies, normalization of eating, medical management and nutritional support, with skills application and community reintegration.

Additional specialized treatment and programming is provided for individuals experiencing concurrent issues including trauma and addiction.

Recovery Management Planning

Prior to discharge, we help our patients connect with outpatient supports and resources in their home communities. Additional Recovery Management programs for depression, anxiety, trauma, addiction, and concurrent disorders are also offered at The Homewood Clinics in major cities, Canada-wide.

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Referral Form for Treatment

Date of Referral : _____

Thank you for referring your patient to Homewood Health (HH). HH offers a comprehensive national continuum of care that focuses on mental health and addiction inpatient and outpatient treatment. If one of our services is outside of your patient's preferred treatment location, or you are unsure of the recommended facility for treatment, please indicate "unknown" in section 1below and we will consult with your patient to help determine the appropriate Homewood Health location.

Section 1: Preferred Referral Location

Inpatient	Outpatient
☐ Homewood Health Centre – Guelph, Ontario	☐ The Homewood Clinic – Vancouver, British Columbia
☐ Ravensview – Victoria, British Columbia	☐ The Homewood Clinic – Edmonton, Alberta
☐ The Residence – Guelph, Ontario	☐ The Homewood Clinic – Calgary, Alberta
	☐ The Homewood Clinic – Mississauga, Ontario
☐ Unknown	

Section 1a. Recovery Management ('aftercare') through Homewood

I am interested in learning about Homewood delivered Recovery Management post-inpatient treatment that may be available in my province/territory.	☐ Yes	☐ No

Section 2: Client/Patient Information

Client/Patient Name:			Gender:
Address:			City:
Province/State:	Postal/Zip Code:		Country: Canada
Date of Birth:	Email Address:		
Home phone:	Mobile Phone:		
Current height:	Current weight:		Allergies:
Occupation:			Employer Name:
Health Card #:			Expiry Date:
Department of National Defense Blue Cross Service # (if applicable):			
Veterans Affairs Canada K # (if applicable):			
Workers Compensation Board # (e.g., WSIB, Worksafe BC):			
Room Accommodation: ☐ Semi-Private ☐ Private *Note, assigned accommodation is based on funder/referring agency approval.*			

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Referral Form for Treatment

Section 3: Primary Reason for Referral & Return to Work Goal (if applicable)

Section 4: Conditions (Check all which apply and indicate which is the primary concern)

In the last 6 months	Prior to 6 months ago	Primary Concern			In the last 6 months	Prior to 6 months ago	Primary Concern	
☐	☐	☐	Acute or Chronic Psychosis *(Thoughts disorder/ hallucination/ delusion)*		☐	☐	☐	Dissociative Disorder
☐	☐	☐	Addiction (drug and/or alcohol)		☐	☐	☐	Eating Disorder
☐	☐	☐	ADHD		☐	☐	☐	PTSD, Abuse, Trauma or OSIs (Occupational Stress Injuries (OSI))
☐	☐	☐	Anxiety Disorder (Social Phobia or panic disorder)		☐	☐	☐	Major Depression (Unipolar)
☐	☐	☐	Autism or Autism Spectrum Disorder		☐	☐	☐	OCD (Obsessive Compulsive Disorder)
☐	☐	☐	Bipolar Disorder (Hypomania, mania, depression)		☐	☐	☐	Personality Disorder
☐	☐	☐	Chronic Pain		☐	☐	☐	Schizophrenia
☐	☐	☐	Cognitive Disorder (Head injury, memory problems)		☐	☐	☐	Substance Abuse (drug and/or alcohol)
☐	☐	☐	Dementia					
☐	☐	☐	Other (please describe) :					

Section 5: Current Safety Risks (Check all which apply)

☐ Current active suicidal thoughts
☐ Current legal issues / ☐ past legal issues
☐ Current passive suicidal thoughts
☐ Current thoughts of harm to others
☐ Dissociation
☑ Flashbacks

☐ History of fire setting
☐ History of suicide attempts Date of last attempt: 2021-03-11
☐ History of violence towards self (self-harm)
☐ History of violence toward others or property
☐ Risk of falling, history of recent falls
☐ Wandering / AWOL risk

Please provide additional details regarding risks identified above:

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Referral Form for Treatment

Section 6: Post-discharge Care Provider

Name:		
Address:		City:
Province/State:	Postal/Zip Code:	Country: Canada
Email:	Phone:	Fax:

Section 6a: Post-discharge Community Care Provider (non-Homewood)

Name:		
Address:		City:
Province/State:	Postal/Zip Code:	Country: Canada
Email:	Phone:	Fax:

Section 7: Referrer Information

Your Name:		
Your Health Care Discipline (e.g. Family Medicine, Social Worker):		
If applicable, Physician/NP Billing #:		
If applicable, Agency (ex. WSIB, DND, VA):		
Address:		City:
Province/State:	Postal/Zip Code:	Country: Canada
Email:	Phone:	Fax:
If you are from a Health Care Discipline, will you provide this patient care after discharge? ☐Yes ☐No		

Section 8: Referral Information

In order to arrange a timely admission to the most appropriate program, please provide us with clinical information from the past 6 months. Copies of past consults, test results and discharge summaries are very helpful.

Referral documentation attached: ☐Medication List ☐Consent Forms Other:

Is this patient an urgent referral? ☐Yes ☐No | Is the patient aware of the referral? ☐Yes ☐No

Section 9: Recent Admissions

1. Has the patient had any psychiatric and/or medical hospitalizations within the last 5 years? ☐Yes ☐No
   If yes, Where: When: Why:
   Please forward discharge notes or consults from hospital stays
2. Is the patient currently in a hospital? ☐Yes ☐No
   If yes, Where: Date of admission:
3. Is their current status involuntary? (certified inpatient) ☐Yes ☐No
4. Has the patient tested positive for: ☐C-Difficile ☐MRSA ☐VRE

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Referral Form for Treatment

Section 10: Group Ready

☐No	☐Yes	Is the patient able to participate in a group based program?
☐No	☐Yes	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)?

Section 11: Current Medications

1. List here or attach a list (using the format below) of all current medications and supplements:

Name	Dosage	Frequency	Reason for Use

2. Does the client/patient take prescribed opiates? (e.g., Codeine, Methadone etc.) ☐Yes ☐No

If yes, ☐for pain, ☐for addiction.

Section 12: Significant Medical History

List all applicable conditions (e.g., diabetes hypertension, etc.)

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Referral Form for Treatment

Section 13: Addiction

1. Does the patient currently have any drug or alcohol (substance) problems? ☐Yes ☐No *If no, skip to section 14*			
First substance of choice is:		Years of use:	Amount used per day:
Second substance of choice is:		Years of use:	Amount used per day:
2. Has the patient ever experienced severe withdrawal symptoms from alcohol or drugs (e.g., DTs, psychosis, seizures or hallucinations)? ☐Yes ☐No If yes, describe:			
3. Does the patient admit to having a drug or alcohol problem? ☐No ☐Yes			
4. Is the patient currently prescribed the following medications? *Note: some programs have specific admission requirements concerning methadone treatment.*	**Dosage:**	**Prescribed for:**	**Comments:**
Methadone ☐No ☐Yes	mg/day	☐addiction treatment ☐ chronic pain management	
Suboxone ☐ No ☐Yes	mg/day	☐addiction treatment ☐chronic pain management	
5. Is the client/ patient using medical marijuana? ☐Yes ☐No Comments:			
6. Does the client/patient use nicotine? ☐Yes ☐No Comments:			

Please note, all inpatient facilities are tobacco free

Section 14 (if applicable):

If you are referring to the Eating Disorders Program at Homewood Health Centre additional information will be needed. Forms will be forwarded to the patient.
If you are referring for Traumatic Stress Recovery, please indicate all the types of trauma the client/patient has experienced: ☐Violence ☐Accident ☐Occupational ☐Military ☐Childhood ☐Other:

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Homewood Health Centre Patient Information Form

You have been referred for admission to Homewood Health Centre. To prepare for your arrival, we need some 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
Phone: 519-824-1010 ext 32551 **Fax:** 519-767-3533 **Email:** admit@homewoodhealth.com

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

Today's Date:	Title:	Last Name:		Given Name:
Preferred Name:		Middle Name:		Alias:
Preferred Pronouns:	Gender Identity:		Biological Sex:	Date of Birth:
Address: ☐ No current address				City:
Province/State:	Postal/Zip Code:			Country: Canada
Home Phone:	Business Phone:		Ext:	Cell phone:
Email:	Preferred Method of Contact: ☐Home Phone ☐Cell Phone ☐Email			
Health Card Number:	Version Code:		Issuing Province:	
Health Card Name (if different from above):		or reason for no HC#:		

TREATMENT PROVIDER INFORMATION

Referring Physician/Clinician:	Disability Case Worker:
Family Physician:	Phone:
Address:	

PATIENT INFORMATION

What type of accommodation are you requesting? ☐Ward ☐Semi-Private ☐Private		
Why have you been referred for a Homewood admission?		
For this admission to be successful, what do you want to see happen or change?		
Please list any allergies (e.g., medication, foods, insects):		
Are you pregnant?	☐Yes ☐No	If yes, when are you due:
Are you currently involved in a clinical drug study/trial?	☐Yes ☐No	If yes, explain:
Have you had a flu shot in the last year?	☐Yes ☐No	If yes, please bring documentation of this
Your height:	Your weight:	

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Homewood Health Centre Patient Information Form

SAFETY QUESTIONS

Do you have a history of:					
☐Yes	☐No	Falling?	☐Yes	☐No	Suicide attempts?
☐Yes	☐No	Fire setting?	☐Yes	☐No	Violence towards property?
☐Yes	☐No	Self-harm (e.g. cutting, burning, etc.)	☐Yes	☐No	Violence towards others?
☐Yes	☐No	Sexual aggression?	☐Yes	☐No	Wandering or leaving hospital without permission?
☐Yes	☐No	Currently are you able to maintain the safety of yourself and others in an unlocked hospital setting without constant supervision?			
Additional comments:					

GROUP READINESS AND FUNCTIONING

☐Yes	☐No	Are you fluent in English?	If no, other preferred language:
☐Yes	☐No	Are you limited in your ability to walk? If yes, you may wish to bring a cane, walker, wheelchair or electric wheelchair.	
☐Yes	☐No	Do you require our assistance to participate in group programming due to significant limitation of your vision or hearing?	How can we help?
☐Yes	☐No	Do you plan to bring a service animal?	

SUBSTANCE USE HISTORY

☐Yes	☐No	Some Homewood programs require supervised urine drug testing. Do you agree to urine drug testing if ordered by the Homewood physician?
☐Yes	☐No	Do you use tobacco products (e.g. smoke)?
☐Yes	☐No	Do you use medical marijuana?
☐Yes	☐No	Do you take methadone? If yes, amount used daily: For ☐addiction or ☐chronic pain
☐Yes	☐No	Do you take suboxone? If yes, amount used daily: For ☐addiction or ☐chronic pain
☐Yes	☐No	Do you use alcohol or any addictive substance? If yes, please fil out the following table:

	Date of last use?	**Amount used per day?**		**Date of last use?**	**Amount used per day?**
Alcohol			Opiates		
Cocaine			Other:		
Marijuana			Other:		

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Homewood Health Centre Patient Information Form

LEGAL QUESTIONS

☐Yes	☐No	Are you facing any criminal charges currently?	If yes, please describe:
☐Yes	☐No	Is your treatment court mandated (required by a court order)?	
☐Yes	☐No	Do you have any upcoming court appearances scheduled to testify, defend against charges or receive sentencing?	If yes, when?
☐Yes	☐No	Are you currently on probation?	
☐Yes	☐No	Have you ever been found NCR (Not Criminally Responsible)?	
☐Yes	☐No	Do you have a criminal record?	Please describe:

PAST ADMISSIONS

☐Yes ☐No Have you had a previous admission to Homewood and/or other psychiatric or addiction facilities?

If yes, please list any admissions:

Year Admitted:	**Facility:**	**Length of Stay:**

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

CURRENT TREATMENT

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

Name of Service:	Contact:	Telephone:

If yes, please list:

Are you currently participating in any self-help groups? ☐Yes ☐No

CURRENT EMPLOYER

Name:		Phone Number:
Address:		City:
Province/State:	Postal/Zip Code:	Country:

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Homewood Health Centre Patient Information Form

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

Name:		Relationship to Patient:
Address:		City:
Province/State:	Postal/Zip Code:	Country:
Phone:	Alternate Phone:	Email:

NEXT OF KIN CONTACT INFORMATION Please provide telephone number(s) where messages can be left

☐ Same as above, if not complete below:

Name:		Relationship to Patient:
Address:		City:
Province/State:	Postal/Zip Code:	Country:
Phone:	Alternate Phone:	Email:

PHARMACY INFORMATION

Pharmacy Name:		Phone:
Address:		City:
Province/State:	Postal/Zip Code:	Country:
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.

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Homewood Health Centre Patient Information Form

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:		Phone:
Address:		City:
Province/State:	Postal/Zip Code:	Country: Canada

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

INSURANCE INFORMATION

Note: Please forward a copy of your benefit card.

Primary Insurer:

Name of Insurance Company:		Employee Number:
Group Policy Number:		I.D. or Certificate Number:
Subscriber's Name:		Subscriber's Date of Birth:
Subscriber's Address (if different):		City:
Province/State:	Postal/Zip Code:	Country:
Subscriber's Employer:		Subscriber's Phone Number:
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:
Subscriber's Address (if different):		City:
Province/State:	Postal/Zip Code:	Country:
Subscriber's Employer:		Subscriber's Phone Number:
Patient's Relationship to Policy Holder: ☐Holder ☐Spouse ☐Dependant ☐Student (full-time) ☐Student (part-time)		

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Homewood Health Centre Patient Information Form

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 verificationthat 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 atHomewood 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 withthis 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).*

Signature:	Date:

Please note that Homewood Health offers a comprehensive continuum of care that focuses on mental health and addiction inpatient and outpatient treatment. If one of our services beyond the Homewood Health Centre is deemed beneficial to meet your needs, we will have intake from the appropriate Homewood Health service connect with you about all Homewood Health has to offer.

Homewood is compliant with current privacy legislation. Homewood collects personal information for assessment and treatment, as wellas 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 32443.

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Treatment at Homewood Health Centre during COVID-19

The health, safety and wellbeing of our patients, staff and volunteers is Homewood Health's priority. We have put the following measures in place for everyone's protection.

14 DAY ADMISSION RESTRICTIONS:

- You will be given a wristband to wear **at all times** for your first 14 days of treatment
- During this time, you will not be able to use the Recreation Centre, fitness or yoga rooms, gymnasium, Library or patient dining room except during scheduled program use (Horticulture Therapy, Creative Arts, Recreation Therapy in the gymnasium etc.)
- Your meals will be delivered to your unit for you to eat in your room or in your unit's common area

MASK USE:

- You are required to **wear a mask at all times** throughout your admission (including when you are in our fitness and yoga room)
- The only exceptions are:
    - When you are outside on the grounds **and** are able to physically distance from others by at least two meters (six feet)
    - When you are in your own room **and** are able to physically distance from your roommate (if applicable), and when you are asleep

GROUNDS PRIVILEGES:

- You are limited to grounds privileges only which mean that **you are not to leave Homewood's property for the duration of your admission**
- Doing so may result in your immediate discharge

VISITORS:

- You may designate one visitor (over the age of 18) **for the duration of your admission**
- This person will remain your designated visitor throughout your treatment; your designated visitor **cannot be changed**
- Visitors will be scheduled for pre-arranged, one hour visiting time slots on dedicated days
- **We are not able to accommodate last minute visits or "walk-ins"**
- Scheduled, one-hour visits will take place on **the unit only**
- The visitor will be asked to show photo ID at the entrance and will be screened, including a temperature reading, before they enter for each visit
- You and your visitor **must be wearing masks throughout the visit**
- Physical distancing (six feet/two meters apart) must be maintained **at all times**, **including** between you and your visitor
- Any packages being brought in by visitors will be checked to ensure contents comply with our safety policies
- A reminder **that outside of scheduled visits with your designated visitor, there are still no unscheduled visits permitted**. An unscheduled visit is any in-person interaction (regardless of whether any physical contact is made) with someone who is not currently on active duty affiliated with the work of Homewood, is not a current patient admitted to or actively participating in the services of Homewood, and is not your designated visitor during an on-unit, scheduled visit. **If you are in breach of Homewood's visitor policy you may have your 14 day admission restrictions re-started** (if applicable), restricted to your unit and discharge may be considered.

PACKAGE DELIVERIES:

You are asked to limit your package deliveries to four (4) deliveries per admission
Packages are processed by our loading dock Monday to Friday – you will not be able to retrieve your package directly from the loading dock
All packages delivered will be opened under supervision of a staff member to ensure the contents are complying with our safety policies

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Treatment at Homewood Health Centre during COVID-19 [cont.]

DROP OFF OF ITEMS:

- Your friends and family are able to drop off items for you to a member of our screening team via the Delhi Street entrance
- You parcel will then be kept in a locker until you and a member of your care team can retrieve it and checked to ensure the contents are complying with our safety policies
- A reminder that **this is not an opportunity to visit** and doing so will be considered a breach of our visitor policy

FOOD DELIVERIES:

- If you order food to the Health Centre via a delivery service, please pre-pay, **wear your mask** when you retrieve your food and **maintain physical distance** from the delivery person
- Your food deliveries may be inspected at the discretion of your care team

OFFSITE APPOINTMENTS:

- If you are approved to leave Homewood grounds for an appointment offsite (i.e. a medical appointment), you will need to wear a mask
- Upon return to Homewood, the **14 day admission restrictions outlined above will restart** and you will be provided with a new wristband (if applicable)

This document is subject to change as we continue to monitor COVID-19 and we are taking the precautions outlined above extremely seriously. They are in place to limit the risk of exposure to the COVID-19 virus and protect our patients, your loved ones and our staff.

Thank you in advance for your cooperation.

I have read and understand the above and I agree to comply with all outlined guidelines in this document throughout my admission. I acknowledge that these guidelines may change during my treatment and that I will follow direction of Homewood Health Centre staff on these and any other matters related to the COVID-19 pandemic.

I also understand that any breach in the above guidelines may result in consequences, potentially including restarting my 14 day admission restrictions, limiting my privileges to my unit only, or discharge from my program and Homewood Health Centre.

_____ _____

Patient Signature Witness

_____

Date

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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.To complete this process, the following information is required:

1. The **Eating Disorders Program Assessment Form**, completed by a Physician.
2. Your patient's **sTSH, GGT, CBC, Calcium, Magnesium, Creatinine, Phosphorus,Fasting Blood Sugar and Electrolyte Panel- Sodium/Potassium/Chloride/Bicarbonate/** values. (within the previous month).
3. Your patient's **results of a recent ECG** (within the previous month).
4. The **Eating Disorders Program Questionnaire**, completed by your patient.
5. The **Patient Information Form**, completed by your patient.

In order to confirm your patients continued medical stability while on the waitlist, you may becontacted to provide updated lab work and ECG.

Please return the above information to our office as soon as possible. If you wish to fax thisinformation, please use our confidential fax number, which is 1-855-704-0501.

If you have any questions, please contact the Admitting Department at 1-519-824-1010ext 32551.

Thank you,

Admitting Department
Homewood Health Centre

For more information about our program, contact us at:
admit@homewoodhealth.com Homewood Health Centre 150 Delhi St.,
Guelph ON N1E 6K9 **Telephone:** 1-866-839-2594 or 519-824-1010 ext 32551
Fax: 519-767-3533

EDP REFERRAL FORM FOR TREATMENT

TO BE COMPLETED BY HEALTH CARE PROVIDER AND FAXED TO:
ADMITTING DEPARTMENT **519-767-3533** (Please use black ink.)

1. PATIENT'S NAME : _____

Name of Health Care Provider: _____

Heath Care Provider's Profession: _____

2. Area of Focus for Treatment and Recommended Treatment Goals:

3. 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.)

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EDP REFERRAL FORM FOR TREATMENT

Name of Patient: _____

4. 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)	☐	☐

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EDP REFERRAL FORM FOR TREATMENT

Name of Patient: _____

5. 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	☐	_____

6. *Additional Findings: (Please explain any abnormal findings.)

Date:_____ Signature: _____

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EDP - Patient Information Form

Name: _____

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

Please note: This form must be completely filled out and returned to **the Admitting Department –Psychiatry Services**, Homewood Health Centre, before we can confirm your suitability for the program. Allinformation 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
☐	☐	☐	☐	☐

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EDP - Patient Information Form

Name: _____

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 select all that apply)	☐	☐
r.	Being fearful about gaining weight	☐	☐

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EDP - Patient Information Form

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?

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 relationshipdifficulties, 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:

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EDP - Patient Information Form

Name: _____

TREATMENT HISTORY

Please describe any treatments you have accessed/tried in order to address your eating disorder. Which treatments have been the most effective? Least effective?

TREATMENT GOALS

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

Date:_____ Patient Signature: _____

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