North Shore Youth Eating Disorders Program
NEW CLIENT REFERRAL

The **North Shore Youth Eating Disorders Program (NSYEDP)** is a multidisciplinary team consisting of a pediatrician, registered nurse, dietitian, and counsellor. This team will provide outpatient assessment and treatment for youth 12 to 19 years of age who have symptoms of anorexia or bulimia and who live in the North Shore, Sunshine Coast, and the Sea to Sky area.

Please Note: Youth up to age 17 years and still in high school will be assessed by our pediatrician. Youth aged 18-19 may be assessed by Foundry medical staff, if necessary. All youth in our program require regular medical follow up by their Primary Care Provider.

We are not an emergency service and we hold a waitlist. If your patient requires urgent care, please refer directly to your local hospital.

Referral Criteria:

The NSYEDP services clients with Anorexia Nervosa, Bulimia Nervosa or Other Specified/ Unspecified Eating Disorder (formerly Eating Disorder Not Otherwise Specified)

The patient will have:

a) An intense preoccupation and concerns with body shape and size

AND

b) Significant low weight or weight loss due to voluntary restricting of food intake

OR

c) Binge eating accompanied by feeling out of control (i.e. can't stop binge or control how much is eaten) **and** purging behaviour (i.e. vomiting, laxatives, post-binge fasting, excessive exercise)

Exclusion criteria:

The NSYEDP **does not** provide services in the following instances:

a) Medically unstable patient (call peds on call at LGH)
b) Alcohol or substance abuse is the primary presenting problem
c) The client is acutely suicidal or in crisis
d) Acute psychiatric disorders account for decreased food intake such as:
    - Thought Disorders (e.g. someone with schizophrenia who has delusions around food)
    - Major Depression or Anxiety where decreased food intake is due to mood
e) Binge eating disorder (i.e. binge eating without any compensatory behaviour)
f) Avoidant Restrictive Food Intolerance Disorder - ARFID

Medical Instability-Admit for 1 of:

Glucose <3.0mmol/L
Potassium <3.0mmol/L
Phosphate <0.8mmol/L
Magnesium 0.7mmol/L
Any ECG abnormalities, including QTc>0.46s
Resting supine HR <45/min
Hypotension <85/45mmHg
Orthostatic drop in BP>20mmHg
Temperature (oral) <36C

Please see **Eating Disorder Toolkit for Primary Care Providers** for more information.
https://keltyeatingdisorders.ca/wp-content/uploads/2017/05/PCP-Eating-Disorders-Toolkit.pdf

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Promoting wellness. Ensuring care.

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Complete the form in full *and fax to Foundry (604) 984-5061*
If you have any questions, please call (604) 984-5060

Date of Referral: _____

REFERRAL SOURCE: (Primary Care Provider: GP, Nurse Practitioner) Name:	
Office Phone:	Office Fax:
Address:	

CLIENT INFORMATION: Client's Surname:	Client's First Name/ Preferred Name:
Gender:	DOB: (yyyy/mm/dd) Age:
Current Address (include postal code):	
Youth Cell:	Can messages be left? ☐ Yes ☐ No ☐ Discreet Only
Parent/Guardian Name: Parent Cell: Parent Email:	May we contact the Client's Parents/Guardian/Contact? ☐ Yes ☐ No When youth has consented to parental contact, initial contact will be made with parent
PHN:	School Attending: Grade:

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MEDICAL EXAM: ***(**THE MEDICAL EXAM AND VITAL SIGNS MUST BE COMPLETED IN FULL FOR THE REFERRAL TO BE ACCEPTED **)***

Current Weight: _____ Current Height: _____BMI: _____

Lowest Weight: _____ Date: _____

Highest Weight: _____ Date: _____

VITAL SIGNS:

Temperature: _____ Respirations: _____

Pulse (Lying): _____ Pulse (Standing): _____

B.P. (Lying): _____ B.P. (Standing): _____

MEDICAL HISTORY:

Medical causes of low weight or vomiting ruled out? ☐ Yes ☐ No

Amenorrhea: ☐ Yes ☐ No Last menstrual period: _____

Oral contraceptive: ☐ Yes No ☐

Diabetes:

_____

GI Disorders:

_____

Allergies:

_____

Other medical conditions or relevant history:

_____

Current Medications (Please list with dosage):

_____

_____

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EATING DISORDER BEHAVIOURS:

Restricting: ☐ Yes ☐ No **Describe**: _____

_____

Purging: ☐ Yes ☐ No **Frequency**:_____

☐ Vomiting
☐ Laxatives
☐ Other (diuretics, thyroid medications, ipecac, appetite suppressants, insulin manipulation etc.)

Describe:_____

_____

Binge Eating: (Eating an objectively large amount of food within any 2 hour period)

☐ Yes ☐ No **Frequency**:_____

Describe: _____

_____

Exercise – hours per week: ☐ 0-3 ☐ 4-10 ☐ 10-15 ☐ 15-20 ☐ 20-30 ☐ 30 +

PSYCHIATRIC HISTORY:
Please describe any psychiatric symptoms of concern or current diagnoses: (i.e. co-morbid psychiatric dx, suicidal ideation, self-harm, substance abuse)

			Quantity
Alcohol	Y	N	_____
Nicotine	Y	N	_____
THC	Y	N	_____
Marijuana	Y	N	_____
Other			_____

_____

_____

Is the patient accessing any other psychiatric or psychological support? If so, where and with whom?

_____

_____

Additional comments & considerations: _____

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WORKING EATING DISORDER DIAGNOSIS:

☐ Anorexia Nervosa ☐ Bulimia Nervosa

☐ Other Specified or Unspecified Eating Disorder (formerly Eating Disorder Not Otherwise Specified)

Lab Work – A current (within 2 months) copy of the following is required:

1) ECG
2) Full blood biochemistry **including <u>all</u> of the below**:

• CBC and diff • Ferritin • Random blood glucose • TSH Free T4 • ALT, AST, Alk Phos, Bilirubin, GGT • LH, FSH, estradiol • 25 OH vit D, B12	• ttG and IgA • Serum Protein • Na, Cl, K, Bicarb • BUN, Creatinine • Serum Phosphate, Magnesium, Zinc

<u>PLEASE COMPLETE THE REFERRAL FORM IN FULL AND INCLUDE COPIES OF REQUIRED LAB WORK AND ECG TO PREVENT DELAY</u>

☐ I understand the North Shore Youth Eating Disorder Program is an outpatient eating disorders service and will not assume responsibility for the primary care of this client. Ongoing care is the responsibility of me, the referring Primary Care Provider.

Primary Care Provider Signature Date

Please fax completed referral to: 604-984-5061

If you have any questions about the services offered or about completing the referral, please call us at 604-984-5060

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