VCH Eating Disorders Program
3rd Floor 2750 East Hastings
Vancouver, BC V5K 1Z9
Phone: 604-675-2531
Fax: 604-675-3894

Vancouver Coastal Health Eating Disorders Program
NEW CLIENT REFERRAL 2025

Referral Criteria:

The Eating Disorder Program will accept referrals for clients 12 years of age and older with eating disorders as outlined in the DSM-5. Please see Page 6 for more information on diagnostic criteria and indicate your provisional diagnosis. C&Y Programming is offered to clients 12 -18 years of age and Adult Programming is offered to clients 19 years of age and older.

- Clients are required to be followed by a primary care provider (i.e. GP, nurse practitioner, or pediatrician) and this physician must complete the referral form and sign Page 5. We are unable to process referrals from Urgent Care, ER or Psychiatry.

- Clients must be residents of Vancouver. We also see adults 19 or older who live in West/North Vancouver, Sea Sky Corridor up to Bella Coola and the Sunshine Coast including Powell River. Children and youth from West/North Vancouver, Sea Sky Corridor up to Bella Coola and the Sunshine Coast including Powell River must be referred to the North Shore Youth Eating Disorder Program Phone: 604-984-5060

Exclusion criteria:

The EDP does not provide services in the following instances:

a) Alcohol or substance abuse is the primary presenting problem.

b) The client is acutely suicidal or in crisis.

c) 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 Post-Partum Depression where decreased food intake is due to mood.

As part of the referral process, ADULT clients are required to attend an **Information Session**
These are held on the 2nd and 4th Wednesday of the month from 5-6 pm
The Information Sessions are held via Zoom Webinar
Webinar ID: 690 701 067 Password: VCH
Please arrive on time. If you are more than 10 minutes late for the session, you will not be admitted into the session.

- For more information, please visit : https://www.vch.ca/en/location-service/eating-disorders-program-vancouver

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NEW CLIENT REFERRAL

Please complete the form and fax to (604)675-3894. If you have any questions, please contact (604)675-2531

Date of Referral: _____ For Consult Only: _____

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

Client's Surname:	Gender: Preferred Pronouns:
Client's Legal Name: Client's Preferred Name (if different):	DOB: (yyyy/mm/dd) Age:
PHN:	**E-mail:**
Current Address (include postal code):	
Primary Phone # Home/Cell Can Messages be left? Y N Discreet Only	Alternate Phone # Can Messages be left? Y N Discreet Only
Parent/Guardian Name: (Child & Youth)	Phone # **Email:**
May we contact the Client's Parents/Guardian/Contact?	Yes No
Contact Person: (Adult)	Home Phone # Alternate Phone #
Current Height:_____Current Weight: _____ HR lying: _____ HR standing: _____ BP lying: _____ BP standing: _____ ***NOT SELF REPORTED; IN-PERSON HEIGHT & WEIGHT REQUIRED.**	Has there been a recent significant weight loss? ☐ Yes ☐ No Please explain:

EATING DISORDER BEHAVIOURS:

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

_____

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

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

_____

Binge Eating (Eating an objectively large amount of food within any 2 hour period, associated with a loss of control)

☐ Yes ☐ No **Frequency**: _____

Body Image Concerns: _____

Other Comments:

MEDICAL HISTORY:

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

Amenorrhea ☐ Yes ☐ No

Last menstrual period: _____

Oral contraceptive: ☐ Yes ☐ No

Pregnant: ☐ Yes ☐ No Week of Pregnancy at Referral:

Diabetes: (insulin dependent) ☐ Yes ☐ No

GI Disorders: _____

Allergies: _____

Other medical conditions:

Current Medications (Please list with dosage):

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

Is the patient accessing any other psychiatric or psychological support? Other comments?

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

1) ECG

2) Full blood biochemistry including all of the below:

☐
- CBC and Diff
- Ferritin
- Random Blood Sugar
- TSH
- ALT, AST, Alk Phos, Bilirubin
- Serum Phosphate, Magnesium, Zinc
- BUN, Creatinine
- Na, Cl, K, Bicarb
- Serum Protein

3) As part of the "Seek and Treat for Optimal Prevention (STOP) of HIV/AIDS" we ask that a routine HIV test be included. For more information on this initiative please contact the Medical Health Officer for Vancouver at 604-675-3900 and/or visit http://hiv.ubccpd.ca/

4) Microscopic Urinalysis to include Specific Gravity.

PLEASE REMEMBER TO COMPLETE THE REFERRAL FORM FULLY AND INCLUDE COPIES OF REQUIRED LAB WORK AND ECG

Incomplete referral forms result in delays.

- ☐ I understand the VCH 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 the referring Primary Care Provider.

_____ _____

Primary Care Provider Signature Date

Please fax completed referral to: 604-675-3894

If you have any questions about the services offered or about completing the referral, please call us at 604 675-2531

EATING DISORDER DIAGNOSIS:

Anorexia Nervosa: ____Restricting type _Binge-eating/purging type (C&Y and Adult Program)

- Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health).
- Either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain (even though significantly low weight).
- Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Bulimia Nervosa:___Purging type __Non-purging type (C&Y and Adult Program)

- Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:
    - Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
    - A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).
- Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise.
- The binge eating & inappropriate compensatory behaviours both occur at least once a week for 3mth
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Binge Eating Disorder ___ (Adult Program Only)

- Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:
    - Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
    - A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).
- Binge eating episodes are associated with 3 (or more) of the following:
    - Eating much more rapidly than normal
    - Eating until feeling uncomfortably full
    - Eating large amounts of food when not feeling physically hungry
    - Eating alone because of embarrassment.
    - Feeling disgusted with oneself, depressed, or very guilty after overeating
- Marked distress regarding binge eating is present
- At least once a week for 3 months

Other Specified Feeding or Eating Disorder (OSFED) ___ (C&Y and Adult Program)

- To be diagnosed as having OSFED a person must present with a feeding or eating behaviours that cause clinically significant distress and impairment in areas of functioning, but do not meet the full criteria for any of the other feeding and eating disorders
    - E.g. Atypical Anorexia Nervosa: All criteria are met, except despite significant weight loss, the individual's weight is within or above the normal range.
    - Bulimia Nervosa (of low frequency and/or limited duration): All of the criteria for Bulimia Nervosa are met, except that the binge eating and inappropriate compensatory behaviour occurs at a lower frequency and/or for less than three months.

Avoidant Restrictive Feeding Intake Disoder (ARFID) (C&Y Pilot Program Only)

- Please use ARFID specific Pilot Program referral @