Hôpital de Montréal pour enfants
Centre universitaire de santé McGill

Montreal Children's Hospital
McGill University Health Centre

Referral Form
Eating Disorders Program

Referring Professional

☐ GP/Family Doctor ☐ Pediatrician ☐ Psychiatrist ☐ Psychologist ☐ Other (specify): _____	Name: Address: Office phone #: ( ) Office fax #: ( )	Are you the primary care provider? ☐ Yes ☐ No *If not, please indicate primary care provider with contact:*

Patient information - Demographics

Name:	☐ Male ☐ Female
DOB: _____ / _____ / _____ day month year	Primary language: ☐ English ☐ French ☐ Other (specify):
RAMQ#:	Expiry date:
Current address:	Contact numbers: Home number: ( ) Other (please specify: _____): ( ) Can a message be left at this number? ☐ Yes ☐ No

Eating disorder-related information:

Current weight: _____ kg Current height: _____ cm Date:

Lowest wt (kg): _____ kg age or year: _____ Highest wt: _____ kg age or year: _____

******Please provide copy of patient's growth chart(s):*** ☐ attached	LMP :

Orthostatic vitals Date:	Lying (for 3 minutes): HR _____ bpm BP _____ mm Hg	Standing (for 3 minutes): HR _____ bpm BP _____ mm Hg

Eating disorder-related behaviours:
☐ Restriction ☐ Bingeing ☐ Vomiting ☐ Laxatives/diuretic use ☐ Over-exercising
Brief description of <u>duration</u> and <u>frequency</u> of activities:

Medical history:		**Psychiatric history:**	

Current medications:

Attach any relevant reports or investigations:
☐ Recent bloodwork ☐ ECG ☐ Psychiatric reports
☐ Other relevant investigations/reports (please specify: _____)

Please mail or fax this referral to: Adolescent Medicine Program, MCH Gilman Pavillion 1040 Atwater Avenue, Westmount, QC H3Z 1X3 **Fax: (514) 412-4319**	**FOR URGENT REFERRALS** **Please contact the Adolescent Medicine Specialist on-call at the clinic *(514) 412-4481* or through the MCH Switchboard *(514) 412-4400***