Royal Victoria Regional Health Centre

Soldiers' Memorial Hospital Orillia

Simcoe Muskoka Regional
Eating Disorder Program Referral
Phone: 705-728-9090 ext. 43504
Fax to: 705-797-2961

NAME: _____

DOB: _____
(DD/MM/YYYY)

HRN: _____

FORMS THAT ARE NOT COMPLETE, OR NOT CLEARLY PRINTED WILL BE RETURNED.

Date of Referral (dd/mm/yr) ___/___/___
Patient's Name (print first name, last name):
Date of Birth: (dd/mm/yr) ___/___/___ ☐ Under 24.5 years
Home Address:
Home Telephone Number: **Alternate Phone Number:**
Doctor Office Phone Number: **Fax Number:**
Permission to leave message: ☐ Yes ☐ No
Health Card #: **Version Code:**
Parent/Guardian Name:
Relationship to Patient:
Reason for Referral/ Presenting Signs & Symptoms: **(For example: purging, weight loss, restricting, excessive exercise)** **Previous Medical/ Mental Health History:**

WEIGHT & HEIGHT:

Weight: Present ____kg Highest ___kg Lowest ___kg Date__/__/__ Date__/__/__ Date__/__/__ ☐Please provide a growth chart or complete growth history
Height: ____cm Date__/__/__

MEDICAL STABILITY: PLEASE FILL OUT COMPLETELY WITH CURRENT INFORMATION

Blood Pressure	Supine	Standing	Date taken: ___/___/___
Heart Rate	Supine	Standing	Date taken: ___/___/___

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MENSES:

Menarche:
LMP:

WEIGHT CONTROL METHODS	NO	YES	WEIGHT CONTROL METHODS	NO	YES
Food Restriction			Ipecac		
Binging			Diet Pills / Supplements		
Vomiting			Exercise		
Laxatives			Other (please specify)		
Diuretics					

MEDICATIONS:

Prescribed: Name(s), dose and frequency
Non-prescription: Name(s), dose and frequency

ECG & LAB WORK: Please have all the following completed and faxed to us at time of referral

☐Sodium ☐Potassium ☐Chloride ☐Glucose ☐BUN/Creatinine ☐ALT ☐Calcium ☐Magnesium ☐Phosphorus ☐Albumin ☐Total Protein ☐Ferritin ☐TSH ☐CBC/diff ☐ESR ☐Amylase ☐LH ☐FSH ☐T4/TSH ☐ECG

Referring Provider Name:	
Signature:	Date:
Address:	
Phone:	Fax:
Office Private:	

Clinic Use Only:

Received:	
Booked:	
Confirmed:	