GRAND RIVER HOSPITAL
Advancing Exceptional Care

Grand River Hospital - Children and Adolescent Eating Disorder Program
Referral Form

Please complete all the information below and FAX: (519) 745-7649

Referrals are only accepted for the geographical catchment of Kitchener-Waterloo region (including Wellesley, Wilmot, and Woolwich).

REFERRAL INFORMATION
Referring Physician/Nurse Practitioner: Phone: Fax: Billing Number: *Family Physician (if different from above):* Phone: Fax: ☐ Growth curve attached
PATIENT INFORMATION
Last Name: Legal First Name: Preferred Name: Date of Birth (yyyy/mm/dd): Gender: ☐ Female ☐ Male ☐ Non-Binary ☐ Transgender Health Card Number: Address:
CAREGIVER INFORMATION
Caregiver name(s): Relationship to child: Legal/Custody Arrangements: Preferred phone number(s): Email: Is the family aware of this referral?
MEDICAL DIAGNOSIS
☐ AN-R ☐ AN-BP ☐ BN ☐ OSFED ☐ ARFID: *Type:* ☐ *Sensory/Extreme Food Selectivity* ☐ *Lack of Interest* ☐ *Fear of Adverse Consequences – i.e. Choking*

ANTHROPOMETRICS *****If HR is <50, or Postural >30, contact pediatrician on call at Grand River Hospital*****			
Current Weight (kg):		**Current Height (cm):**	
Lowest Weight and Date:		Highest Weight and Date:	
Heart Rate Lying for 2 Minutes:		**Heart Rate Standing for 2 Minutes:**	
Blood Pressure Lying:		**Blood Pressure Standing:**	
Age of Menarche (if applicable)		Last Menstrual Period:	

EATING DISORDER BEHAVIOURS		
Behaviour	**Yes/No**	**Describe Frequency/Type/Specifics**
Food Restriction		
Bingeing		
Vomiting		☐ Insulin Misuse
Laxatives/Diuretics Diet Pills		
Exercise		☐ Competitive athlete