REFERRAL FORM

CHILD & ADOLESCENT

EATING DISORDERS PROGRAM

WRHN
Waterloo Regional Health Network

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).

Referrer Information

Referring Provider:
Phone:
Fax:
Billing Number:
Family Physican *if different from above*:

Incomplete referrals will NOT be accepted. Please complete all information and attach growth chart.

Patient Information

Last Name:	*Caregiver Names*:
First Name:	*Relationship*:
Date of Birth (yyyy/mm/dd/):	*Phone*:
Gender:	*Email*:
Health Card Number:	*Caregiver Aware of Referral?*
Address:	

Anthropometrics

*****If HR is <50, or Postural >30, contact pediatrician on call at WRHN**

Current Weight (kg)	Current Height (cm):
Lowest Weight & Date:	Highest Weight & Date:
Heart Rate Laying 2 min:	Heart Rate Standing 2 min:
Blood Pressure Lying:	Blood Pressure Standing:
Age of Menarche (if applicable):	Last Menstrual Period:
Growth Curve Attached (required):Y/ N	Recent Lab Work Attached: Y/N

Eating Disorder Specifics

◯ AN-R ◯ AN-BP ◯ BN ◯ OSFED

◯ ARFID - *Please circle specifics*: Sensory / Lack of Interest / Fear Adverse Consequences

Briefly describe frequency/details of symptoms, and/or attach clinic note(s):