

Please be aware that one-Link does not offer access to crisis services through this referral form.



If in Crisis, please contact:
Halton COAST (Crisis Outreach and Support Team) 1-877-825-9011
24/7 Crisis Support Peel 905-278-9036
The Gerstein Crisis Center (Etobicoke) 416-929-5200

REFERRAL INFORMATION:

Date of Referral: _____

Reason for Referral at this time: _____

Referrers Name: _____ Organization: _____
 Phone# : _____ Fax #: _____ Billing # (mandatory): _____

PERSON SEEKING SERVICES:

Last Name: _____ First Name: _____ Health Card #: _____

Alternative/Preferred Name: _____ Gender: _____ Date of Birth: _____

Address: _____ No Fixed Address

Is person aware of this referral? Yes No
 Is there a Substitute Decision Maker (SDM)? Yes No
 Is there a Power of Attorney (POA) for personal care? Yes No

PREFERRED METHOD OF COMMUNICATION: Phone
 (For appointment booking only) E-mail: _____

Please check if you agree to have the email consent form sent to above email address for consent to correspond via email

Preferred Call Back Time :

(Monday-Friday) Primary Phone: _____ Do Not Leave Message
 8:00 -10:00AM
 10:00 -12:00PM Secondary Phone: _____ Do Not Leave Message
 12:00 - 2:00PM
 2:00 - 4:00PM
 4:00 - 6:00PM

Mon & Wed Only 6:00-8:00PM

Preferred Language: EN FR Is an interpreter required: Yes No

Other (Specify Language): _____

Barriers to Communication: (i.e. hearing impaired, sight impairment, cognitive issues) _____

ALTERNATE CONTACT (If different from above):

Name: _____ Relationship: _____

Primary Phone: _____ Do Not Leave Message

Secondary Phone: _____ Do Not Leave Message

Before faxing clinical information, please ensure fax number (905-338-2878) is automatically programmed into your equipment. This facsimile transmission is confidential, may contain legally privileged information and is intended for the review by only the individual or party to whom it is addressed, and for no one else. If it is received by someone other than the intended recipient, any dissemination, distribution or copy of this facsimile transmission is strictly prohibited. Please notify us immediately by phone and return the facsimile transmission to us by mail. One-Link is compliant with current privacy legislation. One-Link collects personal information for clinical service coordination assessment and treatment, research, and legal and regulatory purposes.

FOR EATING DISORDER PROGRAM THE BELOW ADDITIONAL INFORMATION IS REQUIRED

Has this person previously received eating disorders treatment? No Yes (please include any past documentation)

If Yes, please specify when and where: _____

Have any other referrals to an eating disorder program been made? If so where: _____

Current Weight _____ (lbs or Kg) **Height:** _____ **BMI:** _____
 Lowest Weight (date) _____ (lbs or kg) _____
 Highest Weight (date) _____ (lbs or kg) _____

Weight Control Methods	Frequency	Duration
Food Intake Restrictions		
Binge Eating		
Induced Vomiting		
Laxative Use		
Exercise Quantity (per week)		
Diet Pills		
Diuretics		
Chewing and Spitting		
Substance Use		
Other		

PHYSICAL EXAMINATION

HR _____ BP _____ Date of last menstrual period (D/M/Y) _____

*Current Medications: (please attach list)
 *Growth Charts (please attach if available)

Please include recent results of the following investigations

- ECG *required
- CBC and differential
- RBC Folate, Vitamin B12
- Glucose
- Urea, Creatinine
- Na⁺, K, Ca²⁺
- AST, ALT, GGT, Alkaline Phosphatase, Bilirubin
- Albumin
- TSH
- Magnesium, Phosphate
- Ferritin
- Amylase
- FSH, LH, estradiol (Halton referrals only)

Please consider this patient for:

- Trillium Health Partners
- Halton Healthcare Services
- Not Sure

Trillium Health Partners-Credit Valley Hospital Eating Disorders Program *Must be 18 or older. Referrals are accepted for individuals who are 17 and within the calendar year of their 18th birthday.

- Inpatient Day Program
- Day Hospital Program
- Transition Program
- Outpatient Program
- Not Sure

Halton Healthcare Services *Adult must have a BMI greater than 16.5

Referrals for clients under the age of 18, we recommend a parent/guardian accompany the client to their appointments

- Outpatient Program

For Program Specific Information please call:

Trillium Health Partners-Credit Valley Hospital Eating Disorder Program - 905-813-4505
 Halton Healthcare Services - 905-338-4432 x4900

EATING DISORDER REFERRALS WILL ONLY BE ACCEPTED FROM A FAMILY PHYSICIAN AND ABOVE INFORMATION MUST BE INCLUDED WITH THE FULLY COMPLETED FORM



www.one-Link.ca