

one-Link Eating Disorders Referral Form:

Fax to 905-338-2878

(for Eating Disorder Programs at Halton Healthcare-OTMH and Trillium Health Partners-CVH

Inquiries: Toll Free: 1-844-216-7411



CLIENT INFORMATION				OHIP #		
Last Name:				First Name:		
Date of Birth (D/M/Y)				Gender:		
Street Address:				City:		Prov.
Phone:				Can a message be left? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Alternate Contact Information:				Relationship:		
Name:						
Phone number:						
Preferred Language:						
Is an interpreter requested? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Barriers to Communication:						
<input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Sight Impairment <input type="checkbox"/> Other						
Is this referral from an Emergency Department Addictions or Mental Health Visit? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Is this referral from a Mental Health Inpatient unit? <input type="checkbox"/> No <input type="checkbox"/> Yes Specify hospital:						
<input type="checkbox"/> <i>Please check if limited consent was obtained, and some information was withheld by the client</i>						
Has this person previously received eating disorder treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Specify when and where:						
Current Weight:	Height:	BMI:	Lowest weight: Date:	Heighest weight: Date:	HR: BP:	Date of last menstrual period:
Current Medications: (list or attach)						
Weight Control Methods		Frequency & Duration		Lab results **MANDATORY		
Food intake restrictions				<input type="checkbox"/> ECG		
Binge Eating				<input type="checkbox"/> Amylase		
Induced vomiting				<input type="checkbox"/> RBC Folate, vitamin B12		
Laxative use				<input type="checkbox"/> Magnesium, Phosphate		
Exercise Quantity (per week)				<input type="checkbox"/> Urea, Creatinine		
Chewing and Spitting				<input type="checkbox"/> CBC & Differential		
Diet Pills				<input type="checkbox"/> Albumin		
Diuretics				<input type="checkbox"/> FSH, LH, estradiol		
Substance Use				<input type="checkbox"/> AST, ALT, GGT, Alkaline Phosphatase, Bilirubin		
Other						
Referral Source Information: (affix sticker or stamp here)				Billing #:		
Professional Designation:				<i>*referrals can only be accepted from a Physician or NP</i>		
Office Address:						
Phone #:						
Fax #:						

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. **Form updated: May 2016**