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?** ☐ **Yes** ☐ **No**
Alternate Contact Information: **Name:** **Phone number:**	**Relationship:**
Preferred Language:	
Is an interpreter requested? ☐ **Yes** ☐ **No**	
Barriers to Communication: ☐ **Cognitive Impairment** ☐ **Hearing Impaired** ☐ **Sight Impairment** ☐ **Other**	
Is this referral from an Emergency Department Addictions or Mental Health Visit? ☐ **No** ☐ **Yes**	
Is this referral from a Mental Health Inpatient unit? ☐ **No** ☐ **Yes** **Specify hospital:**	
☐ *Please check if limited consent was obtained, and some information was withheld by the client*	
Has this person previously received eating disorder treatment? ☐ **No** ☐ **Yes** **Specify when and where:**	

Current Weight:	**Height:**	**BMI:**	**Lowest weight:** **Date:**	**Heighest weight:** **Date:**	**HR:** **BP:**	**Date of last mentrual period:**

Current Medications: (list or attach)

Weight Control Methods	**Frequency & Duration**	**Lab results **MANDATORY**
Food intake restrictions		☐ ECG ☐ TSH ☐ Amylase ☐ Na+, K, Ca2+ ☐ RBC Folate, vitamin B12 ☐ Ferritin ☐ Magnesium, Phosphate ☐ Glucose ☐ Urea, Creatinine ☐ CBC & Differential ☐ Albumin ☐ FSH, LH, estradiol ☐ AST, ALT, GGT,Alkaline,Phosphatase,Bilirubin
Binge Eating		
Induced vomiting		
Laxative use		
Exercise Quantity (per week)		
Chewing and Spitting		
Diet Pills		
Diuretics		
Substance Use		
Other		

Referral Source Information: (affix sticker or stamp here)
Professional Designation:
Office Address:
Phone #:
Fax #

Billing #:
**referrals can only be accepted from a Physician or NP*