

Vancouver Coastal Health Eating Disorders Program NEW CLIENT REFERRAL

Referral Criteria:

The Eating Disorder Program provides treatment to clients with eating disorders as outlined in the DSM-5. Please See Page 5 for more information on diagnostic criteria.

- Clients are required to be followed by a primary care provider or pediatrician if the client is under the age of 12.
- Clients must be residents of Vancouver. We also see adults 19 or older who live in West/North Vancouver. North Shore children and youth must be referred to the North Shore Youth Eating Disorder Program Phone: 604-984-5060

Exclusion criteria:

The EDP does not provide services in the following instances:

- a) Alcohol or substance abuse is the primary presenting problem.
- b) The client is acutely suicidal or in crisis.
- c) Acute psychiatric disorders account for decreased food intake such as:
 - Thought Disorders (e.g. someone with schizophrenia who has delusions around food).
 - Major Depression or Post-Partum Depression where decreased food intake is due to mood.
- d) Binge eating disorder (i.e. binge eating without any compensatory behaviour).

As part of the referral process, ADULT clients are required to attend an **Information Session**
These are held on the 2nd and 4th Wednesday of the month from 5-6 pm
The Information Sessions are held via Zoom Webinar
Webinar ID: 690 701 067 Password: VCH
**Please arrive on time. If you are more than 10 minutes late for the session,
you will not be admitted into the session.**

For more information please visit - http://www.vch.ca/Locations-Services/result?res_id=896

**Vancouver Coastal Health Eating Disorders Program
NEW CLIENT REFERRAL**

*Please complete the form and fax to (604) 675-3894.
If you have any questions, please contact (604) 675-2531*

Date of Referral: _____

| | |
|--|-------------|
| REFERRAL SOURCE: (Primary Care Provider: GP, Paediatrician, Nurse Practitioner) | |
| Name: | |
| Office Phone: | Office Fax: |
| Address: | |

| | |
|---|---|
| Client's Surname: | Gender: |
| Client's First Name: | DOB: (yyyy/mm/dd) |
| PHN: | Age: |
| | E-mail: |
| Current Address (include postal code): | |
| Primary Phone # Home/Cell Can Messages be left? Y N Discreet Only | Alternate Phone # Can Messages be left? Y N Discreet Only |
| Parent/Guardian Name: (Child & Youth) | Phone # Email: |
| May we contact the Client's Parents/Guardian/Contact? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Contact Person: (Adult) | Home Phone # Alternate Phone # |
| Current Height: _____ Current Weight: _____ *Please do not use patient's self- reported weight. If required please weigh patient with back to scale and do not tell them their weight. | Has there been a recent significant weight loss? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain: |

EATING DISORDER BEHAVIOURS:

Restricting: Yes No **Comments:** _____

Purging: Yes No **Frequency:** _____

- Vomiting
 - Laxatives
 - Other (diuretics, thyroid medications, ipecac, appetite suppressants, insulin manipulation etc.)
- _____

Binge Eating (Eating an objectively large amount of food within any 2 hour period, associated with a loss of control)

Yes No **Frequency:** _____

Other Comments:

MEDICAL HISTORY:

Medical causes of low weight or vomiting ruled out? Yes No

Amenorrhea Yes No

Last menstrual period: _____

Oral contraceptive: Yes No

Pregnant: Yes No Week of Pregnancy at Referral: _____

Diabetes: (insulin dependent) Yes No

GI Disorders: _____

Allergies: _____

Other medical conditions:

Current Medications (Please list with dosage):

PSYCHIATRIC HISTORY:

Please describe any psychiatric symptoms of concern or current diagnoses:
(i.e. co-morbid psychiatric dx, suicidal ideation, self-harm, substance abuse)

Is the patient accessing any other psychiatric or psychological support? Other comments?

EATING DISORDER DIAGNOSIS: **Anorexia Nervosa: __ Restricting type __ Binge-eating/purging type**

- Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health).
- Either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain (even though significantly low weight).
- Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

 Bulimia Nervosa: __ Purging type __ Non-purging type (exercise and fasting)

- Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:
 - Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
 - A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).
- Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise.
- The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for three months.
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

 Other Specified Feeding or Eating Disorder (OSFED)

- To be diagnosed as having OSFED a person must present with a feeding or eating behaviours that cause clinically significant distress and impairment in areas of functioning, but do not meet the full criteria for any of the other feeding and eating disorders
 - E.g. Atypical Anorexia Nervosa: All criteria are met, except despite significant weight loss, the individual's weight is within or above the normal range.
 - Bulimia Nervosa (of low frequency and/or limited duration): All of the criteria for Bulimia Nervosa are met, except that the binge eating and inappropriate compensatory behaviour occurs at a lower frequency and/or for less than three months.

Lab Work – A current (within 2 months) copy of the following is required:

- 1) ECG
- 2) Full blood biochemistry including all of the below:
 - CBC and Diff
 - Ferritin
 - Random Blood Sugar
 - TSH
 - ALT, AST, Alk Phos, Bilirubin
 - Serum Phosphate, Magnesium, Zinc
 - BUN, Creatinine
 - Na, Cl, K, Bicarb
 - Serum Protein
- 3) As part of the “Seek and Treat for Optimal Prevention (STOP) of HIV/AIDS” we ask that a routine HIV test be included. For more information on this initiative please contact the Medical Health Officer for Vancouver at 604-675-3900 and/or visit <http://hiv.ubccpd.ca/>
- 4) Microscopic Urinalysis to include Specific Gravity.

PLEASE REMEMBER TO COMPLETE THE REFERRAL FORM FULLY AND INCLUDE COPIES OF REQUIRED LAB WORK

Incomplete referral forms result in delays.

- I understand the VCH Eating Disorder Program is an outpatient eating disorders service and will not assume responsibility for the primary care of this client. Ongoing care is the responsibility of the referring Primary Care Provider.

Primary Care Provider Signature

Date

Please fax completed referral to: 604-675-3894

If you have any questions about the services offered or about completing the referral, please call us at 604 675-2531