BETTER OUTCOMES. TOGETHER.
KINARK
CHILDREN AND YOUTH

Kinark Child and Family Services Eating Disorders Program Referral Form

* Referrals must be completed by a Provider or Nurse Practitioner who will provide ongoing medical management for the duration of the program. Youth aged 12 to 17 are eligible. The adolescent must agree with the referral.

CLIENT INFORMATION

Legal name: _____ **Date of birth (M/D/Y):** _____
Preferred Name (if different than above): _____ **Grade:** _____
Preferred Pronouns: _____ **Accessibility Concerns:** _____
Gender: **Preferred Language:** _____

☐ Female ☐ Non-binary ☐ Other: _____ **Client's contact number:** _____
☐ Male ☐ Transgender **Can a voicemail be left?** ☐ Yes ☐ No
Address: _____ **Person to be contacted:** ☐ Client ☐ Parents/ caregiver

Parents/ caregiver Name	**Address**	**Phone**
_____	_____	_____ **V/M** ☐ Yes ☐ No
_____	_____	_____ **V/M** ☐ Yes ☐ No

Suspected/ diagnosed eating disorder:
☐ Anorexia Nervosa ☐ Bulimia Nervosa
Subtype: ☐ Restrictive ☐ Binge-purge
☐ Avoidant Restrictive Food Intake Disorder ☐ Other Specified Feeding or Eating Disorder
☐ Unspecified Feeding or Eating Disorder

Age of symptom onset: _____

Current Height: _____
Current weight: _____ kg / _____ lb Date weight recorded (M/D/Y): _____
Estimated wellness weight: _____ kg / _____ lb
Current % of wellness weight (Formula: current weight/ideal wellness weight x 100): _____
***Please Note—The program is able to provide treatment to those clients who are > 80% progress weight

REFERRAL SOURCE INFORMATION

Name of Primary Care Provider: _____ **Referral date (M/D/Y):** _____
Address of Primary Care Provider:_____
Phone: _____ **Fax:**_____

☐ I acknowledge this client is medically stable to participate in the program and I agree to provide medical monitoring to my client regularly as needed throughout the Program

Signature of Referring Provider: _____

☐ **I acknowledge this client is medically stable to participate in the program and I agree to provide medical monitoring to my client regularly as needed throughout the Program**
Name of Referring Doctor/NP: _____
Signature of Referring Doctor/NP: _____

****PLEASE INCLUDE THE FOLLOWING MEDICAL RECORDS WITH REFERRAL:**

1) Growth Charts
2) ECG: within the last year (if available)
3) Bloodwork results: within the last 3 months (Labs should include: CBC and diff, electrolytes + extended electrolytes (calcium, magnesium, phosphate), glucose, urea, creatinine, AST, ALT, GGT, alkaline phosphatases, albumin, Vit B12, TSH, Ferritin)
4) Vital Signs: within the last month, please include orthostatic vitals
5) Discharge summaries from any hospitalizations related to eating disorder

DIAGNOSTIC AND MEDICAL INFORMATION

Current weight: _____ kg / _____ lb Current Height: _____
Date weight/height recorded (M/D/Y): _____

ESTIMATED WELLNESS WEIGHT: _____ kg / _____ lb**
(MUST be completed to process the referral – if not completed, there will be delays in processing)

Note: Weight restoration in the process of eating disorder recovery, refers to an individual reaching weight stability. This means that an individual reaches a wellness weight that is healthy for them, meets their nutritional and growth needs, and is a weight that they are able to maintain long-term.

Note: To calculate wellness or progress weight – 1) estimate what their weight should be for their current age based on their weight history 2) look at their BMI percentage and see where they have usually tracked. Please see: Setting Target Weights in Eating Disorder Treatment - FEAST (feast-ed.org)

**Current % of treatment goal weight (formula: wellness weight/current weight x 100):_____

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*Please Note—The program is ONLY able to provide treatment to those clients who are > 80% wellness weight
☐ The client meets wellness weight >80%

☐ This referral is from Ontario Shores - Discharged or expected discharge date: _____
☐ Community Referral from Family MD/NP or other organization

MD/NP Name:_____ Phone #:_____ Fax #: _____

Eating disorder diagnosis:
☐ Anorexia Nervosa ☐ Bulimia Nervosa ☐ Binge Eating Disorder
Subtype: ☐ Restrictive ☐ Binge-purge
☐ Avoidant Restrictive Food Intake Disorder ☐ Other Specified Feeding or Disordered Eating
Age at diagnosis: _____

Other psychiatric diagnosis:
☐ Without comorbid psychiatric diagnosis
☐ With comorbid psychiatric diagnosis
Mood Disorder:
Anxiety:
Affect Regulation Disorder:
Borderline Personality Disorder:
Other/Please specify: including SH ☐ SI ☐ Safety concerns ☐

Other medical diagnosis:
☐ With comorbid medical diagnoses ☐ Without comorbid medical diagnosis
Diagnosis:
Allergies:
☐ Known allergies _____ ☐ No known allergies
Symptoms:
*Food allergies: Medical documentation must be provided to support specific food allergies.

Menstruation History:
☐ Normal
☐ Primary amenorrhea
☐ Secondary amenorrhea (no vaginal bleeding >3 months)

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

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Medication History:

Current medication(s)		
Medication name	Dosage	Reason for starting
Past medication trials		
Medication name	Dosage	Reason for stopping

Please include all prescribed medication and over the counter medications, including bowel meds, vitamins and supplements (attach medication record if available).

EATING DISORDER SYMPTOMS & BEHAVIOURS

Mild = a few times per month; moderate = weekly to several times a week; severe = daily to multiple times a day

Symptom/behaviour	Past	Current	Severity of symptoms/behaviours
Restriction	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Bingeing	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Purging	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Dysfunctional Exercise	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Laxative use	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Ipecac use	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Temperature control	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Rumination	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Chewing & spitting food	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Meal Time Behaviours (Hiding/ Smearing/ Crumbling/ Wiping and etc.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Night eating	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Selective eating	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Other (please comment):	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe

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EATING DISORDER TREATMENT HISTORY

Inpatient and/or Outpatient Eating Disorder Treatment:
Total number of inpatient eating disorder admissions: _____
☐ Currently admitted and planning to discharge home to outpatient

Total number of outpatient eating disorder attempts:
☐ Currently in outpatient treatment
☐ Has received past outpatient treatment

Date	Facility	Reason for admission	Degree of success	Duration