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 18 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:** _____
**Gender:**
☐ 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 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:** _____