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# Referral Form For TBP Eating Disorder Outpatient Program

*** Please note that incomplete referral forms will be returned for completion ***
**Once this form is complete, please send via email to info@thebalancedpractice.com or by fax to (613)-280-1507**

**BEFORE COMPLETING THIS REFERRAL FORM PLEASE READ:**
The TBP Eating Disorder Outpatient Program provides outpatient services for youth (13 y.o +) and adults. For patients under the age of 18, we follow the family based treatment model, therefore, we must obtain consent from the patient to communicate with the parent(s)/caregiver(s).

The patient, _____, gives consent to The Balanced Practice to communicate with the parent(s)/caregiver(s) for the purposes of screening and booking appointments.
▫ YES (patient to sign and date): _____
▫ NO (provide reason): _____

Parent/Caregiver(s) name(s): _____
Phone number:_____
Email: _____

This referral form serves as an application to the TBP Eating Disorder Outpatient Program. Once the form is reviewed, a team member will contact the patient or the parent(s)/caregiver(s) to further assess their eligibility to the program. If appropriate, treatment will be offered to the patient and an initial assessment will be booked.

This program is not suitable for everyone. A patient is appropriate for treatment if:

- They have an eating disorder (diagnosis is not required)
- They have a BMI over 16
- They are medically stable and do not require hospitalisation
- They are ready to commit to treatment and are able to engage via videoconference (cameras need to be on)

**We do not offer inpatient or day hospital treatment.**
If you believe your patient requires inpatient treatment or could require this in the foreseeable future, please refer them to www.ocoped.ca for a list of intensive services in Ontario. The Primary Health Care Provider is responsible for the medical monitoring of their patient while on the waiting list for service and while attending the TBP Outpatient Eating Disorders Program.

**Referral Form For TBP Eating Disorder Outpatient Program**

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**Patient Information**

Date of Referral:_____
First Name: _____
Last Name:_____
Pronouns:_____
Date of Birth (D-M-Y):_____ Age:_____
Sex:_____ Address:_____
City:_____ Postal Code:_____
Telephone:_____
Email: _____
Health Card Number:_____

**Physician Information**

Name of family physician : _____
Address: _____
Telephone: _____
Fax number: _____
▫ I do not have a family physician

Do you have a diagnosis for an eating disorder :
▫ NO
▫ YES :_____ (Specify Diagnosis)

What symptoms are you experiencing:

| **Symptoms** | **No** | **Yes** | **# per day / # per week** |
|---|---|---|---|
| Food Restriction | | | |
| Binge Eating | | | |
| Induced vomiting | | | |
| Laxative use | | | |
| Diet pills or supplements | | | |
| Compulsive exercise use | | | |
| Other: | | | |

Do you have any other health issues? :
▫ NO
▫ YES :_____ (Please Specify)

Do you have any recent blood work results (in the last 4 weeks)?:
▫ NO
▫ YES → please send a copy with application

Are you currently taking any medication and/or vitamin supplementation?:
▫ NO
▫ YES: _____ (Please Specify)

What is your current weight? _____
Have you lost weight in the last 12 months? If so, how much? : _____
What is your current height? _____

Who is making this referral:
▫ I am referring myself
▫ I am a parent/caregiver
▫ I am a health care provider referring a client : _____ (sp

If you are  a referring health care provider, please complete below or stam):
Name: _____
Profession:_____
Address: _____
Telephone: _____
Fax: _____

Does the patient give consent for The Balanced Practice to speak with the Referring Health Care Provider if they are not the one referring? ▫ Yes  ▫No

**Thank you for your referral.**
Our team will contact your patient directly for a telephone screening appointment. If you require any further information please do not hesitate to contact us info@thebalancedpractice.com

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