PCFHC Eating Disorder Support Group
Referral Form

Date of Referral : _____ **Patient's Name:** _____
First Middle Last

Address: _____ Postal Code _____
City Province

Telephone Number: **Home:**(___)_____ Business: ( ) _____

Sex: Female ☐ Male ☐Other:_____ **Title**: Mr. ☐ Mrs. ☐ Miss ☐ Ms.☐ Other:

D.O.B.: _____**Health Card Number:**_____**Version Code:** _____

Other contact Person: _____
Name Relation to Patient Telephone Number

PRESENTING PROBLEM(S) 1. _____

2. _____

3. _____

Current Weight:_____(lb or kg) **Height:**_____ (inches/cm)

WEIGHT CONTROL METHODS: ☐**No** ☐**Yes**

FREQUENCY

Per Day **Per Week**

☐Food Restriction ☐Binge Eating ☐Vomiting ☐Laxatives ☐Diuretics Ipecac Diet Pills

RESULTS OF RECENT LAB WORK:

Potassium:_____Haemoglobin:_____

EKG:_____

ED History and Diagnosis:

_____

_____

_____

_____

MEDICATIONS:

Prescribed: _____

Non-prescribed:_____

REFERRING PHYSICIAN:_____

Full name (please print or type)

Address: _____

Street Address Suite/Apt # / City Province Postal Code

Business:_____ **Physician #**_____

For OHIP billing

Additional Therapist (s):_____

Address:_____

Street Address Suite/Apt #

_____

City/ Province/ Postal Code

Business:_____

PLEASE FAX OR MAIL FORM TO:

Crystal Schimmens, NP
Petawawa Centennial Family Health Centre
154 Civic Centre Road,
Petawawa On,
Phone: 613-687-8538 x120
Fax: 613-687-6808