Guidelines for referrals to the Provincial Specialized Eating Disorders Programs in BC

In the continuum of care for eating disorders treatment in British Columbia,[1] this referral form is shared by the three Provincial Specialized Eating Disorders Programs:

1. **BC Children's Provincial Specialized Eating Disorders Program:** *Provincial tertiary eating disorders program for children and adolescents offering assessment, outpatient, day treatment and inpatient programs. For info see:* http://www.bcchildrens.ca/our-services/mental-health-services/eating-disorders
2. **Looking Glass Residence:** *Provincial residential Eating Disorders program for youth and young adults. For info see:* http://www.bcchildrens.ca/our-services/mental-health-services/looking-glass-residence
3. **The Provincial Adult Tertiary and Specialized Eating Disorders Program at St. Paul's Hospital:** *Provincial tertiary eating disorders program for adults offering assessment, inpatient and outpatient services including intensive day/residence programs. For info see: http://mh.providencehealthcare.org/programs/provincial-adult-tertiary-eating-disorders-program*

Although the referral form is shared, referral criteria vary by program. Please read the following guidelines carefully.

Referring to BC Children's Hospital:

☐ For patients up to 17 years of age who, in the opinion of a medical professional or regional program may have an eating disorder may be referred for assessment.

☐ Referrals are only accepted from: 1) Medical professionals[2]; or 2) Regional eating disorder programs.[3]

☐ If you are not referring from a regional eating disorders program, it is recommended that you also submit a referral to the patient's regional eating disorders program. If patient is also referred to another program, please indicate on referral which program under the "Current psychological or psychiatric treatment" section (p 2).

For more information contact the intake coordinator at 604 875-2106

Referring to Looking Glass Residence:

☐ For clients age 16-24; with a diagnosed eating disorder of AN, BN or OSFED; who are medically and psychiatrically stable; with a BMI of 15+. Clients are supported to reach a BMI of 16+ for entry into the residential program. Clients must have a Primary Care Provider. For full criteria see the Looking Glass website.

☐ LGR is a voluntary residential program. The client needs to be in agreement with this referral.

☐ Referrals are only accepted by: 1) Regional eating disorders programs for patients in locations where regional programs exist[3]; 2) In the absence of a regional program referrals will be accepted through a medical professional or 3) BC Children's Hospital or St Paul's Hospital Eating Disorders Programs.

*Please note, this program has a per diem cost for residents age 19 years and older of $30.90 per day.

For more information contact the intake coordinator at 604 829-2585 extension 2

Referring to Provincial Adult Tertiary and Specialized Eating Disorders Program:

☐ For patients 17 years of age and older with a diagnosed eating disorder of Anorexia Nervosa, Bulimia Nervosa or Otherwise Specified Feeding and Eating Disorder (OSFED) and requires tertiary level of care.

☐ Referrals are accepted by: 1) Regional eating disorders programs for patients in locations where regional programs exist[3]; or 2) In the absence of a regional program referrals will be accepted from mental health teams, and/or other secondary service community care providers.

☐ Patient must be followed by a primary care provider (i.e. Family Physician or Nurse Practitioner).

For more information contact the intake coordinator at 604 806-8654

[1] Patients must be residents of BC (some exceptions may apply).
[2] Medical professionals refers to Family Doctors, Nurse Practitioners, Psychiatrists and other Physicians.
[3] For information on regional eating disorders programs please see http://keltyeatingdisorders.ca/maps or call the Kelty Mental Health Resource Centre at 604-875-2084.

Provincial Specialized Eating Disorders Programs Referral Form

Where are you referring to? (Select one):

☐ **BC Children's Hospital Provincial Specialized Eating Disorders Program / Fax form to: (604) 875- 2099**

For patients up to 17 years of age.

☐ **Looking Glass Residence / Fax form to: (604) 829-2586**

Residential service for patients age 17 to 24. Patients must be medically stable to be referred to this program.

☐ **Provincial Adult Tertiary and Specialized Eating Disorders Program at St. Paul's Hospital / Fax form to: (604) 806-8631**

For patients 17 years and older.

Referring Program/Professional:

Your MSP BILLING # (if applicable): _____

Are you>>> ☐ A Regional Program – specify:_____

☐ Psychologist ☐ GP/Family Doctor ☐ Pediatrician ☐ Psychiatrist

☐ Other – specify: _____

Are you>>> The primary care provider? ☐ Yes ☐ No If No – Give name of Primary Care Provider:_____

_____ Indicate if: ☐ Dr. or ☐ NP Phone #: ( ) _____

Your name: _____ _____ ___ (last / first / initial)	**Office phone #:**	**Office fax #:**
Address City: Postal code:		

Patient information - Personal history

Patient's legal name **(Please print)** **Gender:** ☐ Male ☐ Female ☐ Other _____

_____ _____ _____

Last Name **First Name** **Middle name**

BC PHN # (mandatory) _____ DOB: _____ / _____ / _____ (Year / Month / Day)

Non-BC medical # _____ Province: _____ Expiry date: _____

Primary language: ☐ English ☐ Other, describe: _____

Patient's current address:

Street: _____ Apt #_____ City: _____ Postal code: _____

Patient's current home #: ( ) **Patient's cell #:** ( )

Patient's work # if applicable: ( ) **Other #:** ( )

Caregiver information ✹Mandatory: **For patients under 19 years of age**

CAREGIVER #1		**CAREGIVER #2**	
Relationship to patient:		Relationship to patient:	
Name:		Name:	
Home tel:	Cell:	Home tel:	Cell:
Email:		Email:	

Current psychological or psychiatric treatment: ✹Mandatory: ongoing care reports or current consultations required

☐ Mental Health Team ☐ No Location & #: _____

☐ Psychiatrist ☐ No Name & #: _____

☐ Psychologist ☐ No Name & #: _____

☐ EAP ☐ No Name & #: _____

☐ Therapist/Counselor ☐ No Name & #: _____

Eating disorder related information:

Current HT _____ in / cm Current WT _____ lbs/ kg BMI _____ Date weight taken_____

Lowest WT _____ lbs / kg age or year: _____ Highest WT _____ lbs/ kg Age or year: _____

Heart rate: *lying* _____ *standing* _____ BP: lying _____ *standing* _____ LMP _____

Eating disorder-related behaviours – please describe: ☐ Restriction ☐ Bingeing ☐ Vomiting ☐ Laxatives/diuretics use ☐ Over-exercising

Describe frequency of above activities:

Medical History ☐ Diabetes ☐ Pregnant ☐ Substance Use/Dependent ☐ Allergies

Describe any medical issues and current medications:

Lab work ✹ **Mandatory:** Please provide a copy of the following with this referral:

•CBC • Lytes (+glucose) •CA •MG •PO4 •Ferritin •CR •BUN •ESR •TSH

•ECG → **Send a copy with this form.**

Psychiatric history ✹ Mandatory: previous psychiatric consults or reports required

Describe any psychiatric issues or previous admissions:

Is the patient aware of this referral? ☐ Yes ☐ No **Is the patient agreeable to referral? ☐ Yes ☐ No**

For BCCH/LGR: Is the family aware of this referral? ☐ Yes ☐ No **Is the family agreeable to referral? ☐ Yes ☐ No**

➲ **Important: Please ensure that your patient is referred or connected to a *regional program*** in their area before a referral is made to these Specialized Programs. **See cover sheet for more information on this requirement.**

➲ Information enclosed on and with this referral will be shared with the designated secondary or tertiary service in the patient's health region. This referral may be redirected to one of the other services in the continuum of care in BC if deemed more appropriate to meet patients' needs.