Referrals from Eating Disorder professionals for Discovery/Vista Program

The Provincial Adult Tertiary Eating Disorders Program (PATSEDP) is currently conducting a pilot project between January 3, 2023 and January 2, 2026. Referrals to the Discovery/Vista program will be accepted from psychiatrists, family physicians at the REACH clinic, and practitioners who are experienced in the treatment of eating disorders. Please complete the following referral form with your patient and their primary care provider (PCP) and return to PATSEDP. Incomplete referrals will not be processed.

For questions or inquiries, please reference "Discovery/Vista referral - pilot project."

Completed referrals can be faxed to:

604-806-8631

Attention: Discovery/Vista referral - pilot project

Incomplete referrals will not be processed.

*Note to PCPs: PATSEDP Eating Disorder Internal Medicine consults are available 24/7.

- Monday to Friday, 0700-1500hrs: consult requests are triaged by the Intake Coordinator at 604-806-8654.
- After hours, on weekends & on statutory holidays: call the St. Paul's Hospital switchboard at 604-806-9090 & ask for the on-call eating disorder physician.

For Referring Professional and Client

Thank you for your interest in the Discovery/Vista Program. Please indicate that both the Referring Professional and client understand the below requirements for admission to the Discovery/Vista Program:

☐ Medical stability, as evidenced by lab results (see below) and low risk of re-feeding syndrome; same will be assessed at intake.

☐ Body Mass Index (i.e., BMI) is above 17.0, with willingness to weight restore to BMI of at least 20.

☐ Client is connected with, or waitlisted, at a secondary Eating Disorders Program within client's health authority (if available).

☐ Client is willing and able to engage with the Readiness Program for a minimum of 3 weeks prior to starting the Discovery/Vista Program.

☐ Client is willing and able to commit to 12-15 weeks in the Discovery/Vista Program.

☐ Psychiatric stability, including a willingness to abstain from self-harm, suicidal behaviours, and substance misuse for at least 6-weeks prior to the Discovery/Vista Program and during the Discovery/Vista Program.

☐ Patient has a Primary Care Practitioner (PCP) who supports this referral and can provide ongoing medical care.

☐ Patient will continue to see their Referring Professional at least once per month until admission to the Discovery/Vista Program. Patient to be discharged back to Referring Professional and PCP for continuity of care upon completion of the Discovery/Vista Program, or in the event of an unexpected discharge.

☐ Completion of this referral form. **Incomplete referrals will be returned to the Referring Professional.**

I understand the above requirements for admission to the Discovery/Vista Program.

Patient Name: _____

Patient Signature: _____ Date of signature: _____

PCP's Name: _____

PCP's Signature: _____ Date of signature: _____

Referring Professional's Name: _____

Referring Professional's Signature: _____ Date of signature: _____

We require this form be filled out before we can assess the patient for admission. Applications will be processed when <u>all</u> requested documents are received.

A. **Information about Referring Professional and patient's other care providers**			
Date of Referral: _____			
Referring Professional's	Last Name: _____	First Name: _____	
Address		Office Phone	Office Fax/Email

Referring Professional's profession (must be a member in good standing of a regulatory college under the Health Professions Act):

☐ Registered Dietitian ☐ Registered Psychologist ☐ Psychiatrist ☐ PCP ☐ Other (please specify): _____

For other professionals/programs involved in patient's care, please provide their information:

Program or Professional Name (first/last)	Address	Office Phone	Office Fax/Email

B. **Patient Information**			
Current Age	**Last Name**	**First Name**	**BC PHN**
DOB (DD-MM-YYYY)	**Gender**	**Phone Number**	**Email**
Street Address	**Apartment/Unit #**	**City**	**Province** / **Postal Code**
Marital Status	**Children** ☐ **No** ☐ Yes	**Referral Status** ☐ **New** ☐ **Repeat (initial referral date):** _____	

C. **Eating Disorder History**			
Current Height (in/cm): _____ Current Weight (lbs/kg): _____ Current BMI _____	Amenorrhea ☐ Yes; date of last period: _____ ☐ No ☐ N/A	Weight change in past 3 months ☐ No ☐ Weight Gain _____lbs/kg ☐ Weight Loss _____lbs/kg	Lowest Weight _____lbs/kg at Age _____ in Year _____ Highest Weight _____lbs/kg at Age _____ in Year _____

Date of last visit with PCP: _____		Date of last physical exam: _____	
Food restriction (within last 3 months)	☐ No ☐ Yes	History of Food restriction (please describe):	
Food intake in the last 24-hours:	☐ Less than the equivalent of 2 meals/day	☐ 2 meals or > /day (include snacks)	☐ 3 meals or > /day (include snacks)

Eating Disorder Behaviours in the past 3 months:	**No**	**Yes**	**Frequency**
Binge eating	☐	☐	
Vomiting	☐	☐	
Laxative Use	☐	☐	
Fluid Restriction	☐	☐	
Diuretic Use	☐	☐	
Appetite Suppressants	☐	☐	
Metabolism Booster	☐	☐	
Chewing and Spitting	☐	☐	
Compensatory Exercise	☐	☐	

D. **Psychiatric History (please attach summaries of all treatments if appropriate)**

Current psychological or psychiatric treatment	☐ Mental Health Team	Location: _____
	☐ Psychiatrist	Name: _____
	☐ Psychologist	Name: _____
	☐ EAP	Name: _____
	☐ Therapist	Name: _____
	☐ Other: _____	Name: _____
Previous Eating Disorders treatment	☐ No	☐ Yes (please describe where/when):
Previous psychiatric admissions	☐ No	☐ Yes (please describe where/when):
Previous treatment	☐ No	☐ Yes (please describe where/when):
Suicidal thoughts in last year	☐ No	☐ Yes (please describe when):

Suicide attempts in last year	☐ No	☐ Yes (please describe when):	
Self-harm in last year	☐ No	☐ Yes (please describe when):	
Substance use	**Frequency**	**Amount**	**If stopped, when?**
☐ Alcohol			
☐ Cannabis			
☐ Cocaine			
☐ Amphetamines			
☐ Hallucinogens			
☐ Tobacco			
☐ Other			
Prescribed medications	**Dosage**	**Frequency**	**Taken as prescribed?**

E. **Physical Status** Please see the checklist below on test results to include with this referral.	
☐	Standard physical examination
☐	Fasting blood sugar
☐	CBC with differential
☐	Electrolytes & renal function: potassium, sodium, chloride, bicarbonate, magnesium, phosphate, urea, creatinine
☐	Liver function/coagulation profile: AST, ALT, alkaline phosphatase, bilirubin, LDH, GGT, albumin, total protein, INR
☐	Ferritin
☐	ECG
☐	(Optional) Please include results of bone density scan (e.g., DEXA) if available.