



Adolescent Medicine Referral for Assessment (Part I)

Telephone: (709) 777-4963 Fax: (709) 777-4726

Email Referral To: AdolescentMedicine@easternhealth.ca



Name _____

HCN _____

Date of Birth: _____

Part I is required to be completed in full. Part II is required to be completed in full if applicable. Attach completed screening tools if applicable, as indicated below. **Incomplete referrals will not be processed.** [See referral guidelines](#)

Part I

Referral Date: DD/MONTH/YYYY

REFERRAL SOURCE:	
Name: _____	
Telephone: _____	Fax: _____
Address: _____	
PARENT/CAREGIVER INFORMATION:	
Name: _____	Relationship to child: _____
Address: _____	
Telephone Numbers: _____	Email address: _____
Reason(s) for Referral:	
<input type="checkbox"/> Eating Disorder (complete Part II in full) <input type="checkbox"/> Gender Wellness <input type="checkbox"/> Sexual/Reproductive Health <input type="checkbox"/> Adolescent Anxiety/Depressive Disorders without a preexisting/comorbid mental health diagnosis (must include SCARED and/or PHQ-9: Modified for Teens screening tool) <input type="checkbox"/> Other: _____	
List of Current Medications: _____	
List any Medical/Psychiatric Illness/Comorbidities: _____	
Indicate any Other Services Accessed by Patient:	
<input type="checkbox"/> Pediatrician <input type="checkbox"/> Developmental Pediatrician <input type="checkbox"/> Psychologist <input type="checkbox"/> Social Worker <input type="checkbox"/> Endocrinologist <input type="checkbox"/> Gynecologist <input type="checkbox"/> Dietitian <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Other: _____	

Name: _____

Date: DD/MONTH/YYYY

Signature: _____

Adolescent Medicine Referral for Assessment (Part II)

Telephone: (709) 777-4963 Fax: (709) 777-4726



Name _____

HCN _____

Date of Birth: _____

EATING DISORDER SYMPTOMS:

	Yes	No	Frequency	Exercise/Activity History (Type and Amount):
Food Restriction	<input type="checkbox"/>	<input type="checkbox"/>		
Binge Eating	<input type="checkbox"/>	<input type="checkbox"/>		
Induced Vomiting	<input type="checkbox"/>	<input type="checkbox"/>		
Laxatives	<input type="checkbox"/>	<input type="checkbox"/>		
Diet Pills	<input type="checkbox"/>	<input type="checkbox"/>		
Diuretics	<input type="checkbox"/>	<input type="checkbox"/>		

PHYSICAL EXAMINATION (complete in full)

Current Height		cm	Pulse (lying X 5 minutes)	
Current Weight		Kg	Blood Pressure (lying X 5 minutes)	
BMI			Pulse (standing X 2 minutes)	
Maximum Weight and Date	Kg		Blood Pressure (standing X 2 minutes)	
Minimum Weight and Date	Kg		Temperature	
Recent Weight Loss	Kg		Last Menstrual Period	
			<input type="checkbox"/> Primary Amenorrhea	<input type="checkbox"/> Secondary Amenorrhea

- Order (at time of referral) and attach/forward ECG and Blood Work including: CBC, Ferritin, TSH, BUN, Creatinine, Amylase, Glucose, Calcium, Magnesium, Phosphate, Potassium, Chloride, and Sodium
- Patient cannot be triaged or placed on waitlist without physical exam, ECG and blood work
- The General Practitioner/Nurse Practitioner is responsible for the medical management of the patient while awaiting assessment by the Adolescent Medicine Pediatrician. Refer to [Assessment guidelines for hospitalization of patients with eating disorders](#) . For more information visit the [Adolescent Medicine Website](#).

Name: _____

Date: DD/MONTH/YYYY

Signature: _____

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