Eastern Health

Child/Women's Health Program

Adolescent Medicine Referral for Assessment (Part I)

Telephone: (709) 777-4963 Fax: (709) 777-1486

Email Referral To: AdolescentMedicine@easternhealth.ca

AS6350 2132 03 2020

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:

☐ Eating Disorder (complete Part II in full) ☐ Gender Wellness ☐ Sexual/Reproductive Health

☐ Adolescent Anxiety/Depressive Disorders without a preexisting/comorbid mental health diagnosis (must include SCARED and/or PHQ-9: Modified for Teens screening tool)

☐ Other:

List of Current Medications:

List any Medical/Psychiatric Illness/Comorbidities:

Indicate any Other Services Accessed by Patient:

☐ Pediatrician ☐ Developmental Pediatrician ☐ Psychologist ☐ Social Worker

☐ Endocrinologist ☐ Gynecologist ☐ Dietitian ☐ Psychiatrist

☐ Gastroenterologist

☐ Other:

Name: _____ Date: DD/MONTH/YYYY

Signature: _____

Eastern Health
Child/Women's Health Program

Adolescent Medicine Referral for Assessment (Part II)

Telephone: (709) 777-4963 Fax: (709) 777-1486

AS6350 2132 03 2020

Name

HCN

Date of Birth:

EATING DISORDER SYMPTOMS:

	Yes	No	Frequency
Food Restriction	☐	☐	
Binge Eating	☐	☐	
Induced Vomiting	☐	☐	
Laxatives	☐	☐	
Diet Pills	☐	☐	
Diuretics	☐	☐	

Exercise/Activity History (Type and Amount):

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 DD/MONTH/YYYY	Blood Pressure (standing X 2 minutes)	
Minimum Weight and Date	Kg DD/MONTH/YYYY	Temperature	
Recent Weight Loss	Kg	Last Menstrual Period ☐ Primary Amenorrhea ☐ 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: _____

Email Referral To: AdolescentMedicine@easternhealth.ca