

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 professionals²; 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 exist³; 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 exist³; 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



How you want to be treated.



Provincial Health Services Authority
Province-wide solutions.
Better health.



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.