BETTER OUTCOMES. TOGETHER.
KINARK
CHILDREN AND YOUTH

Kinark Child and Family Services
Outpatient Eating Disorders Program Referral Form

*Referrals must be completed by a Family Doctor or Nurse Practitioner who will provide ongoing medical management for the duration of the program. Youth aged 12 to 17 are eligible. The adolescent must agree with the referral.

☐ This referral is from Ontario Shores - Discharged or expected discharge date: _____
☐ Community Referral from Family MD/NP

CLIENT INFORMATION

Legal name: _____ Date of birth (M/D/Y): _____
Preferred Name (if different than above): _____ Grade: _____
Preferred Language: _____ Accessibility Concerns: _____
Gender: Preferred Pronouns: _____
☐ Female ☐ Non-binary ☐ Other: _____ Client's contact number: _____
☐ Male ☐ Transgender Can a voicemail be left? ☐ Yes ☐ No
Address: _____
Person to be contacted: ☐ Client ☐ Parents/ caregiver

Parent/Caregiver Name: Address: Phone:
_____ _____ _____ V/M ☐ Yes ☐ No
_____ _____ _____ V/M ☐ Yes ☐ No

DIAGNOSTIC AND MEDICAL INFORMATION

****Weight and height are required to be checked within 2 weeks of referral**

Current weight: _____ kg / _____ lb Current Height: _____

Date weight/height recorded (M/D/Y): _____

ESTIMATED WELLNESS WEIGHT: _____ kg / _____ lb

Current % of treatment goal weight (current weight/ wellness weight x 100):_____

***Please Note—The program is ONLY able to provide treatment to those clients who are > 80% target wellness weight. Weight restoration, in the process of eating disorder recovery, refers to an individual reaching weight stability. This means that an individual reaches a wellness weight that is healthy for them, meets their nutritional and growth needs, and is a weight that they can maintain long-term. To calculate wellness or progress weight – 1) estimate what their weight should be for their current age based on their weight history 2) look at their BMI percentage and see where they have usually tracked. Please see: Setting Target Weights in Eating Disorder Treatment - FEAST (feast-ed.org)**

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Eating disorder diagnosis:

☐ Anorexia Nervosa ☐ Bulimia Nervosa ☐ Binge Eating Disorder

Subtype: ☐ Restrictive ☐ Binge-purge

☐ Avoidant Restrictive Food Intake Disorder ☐ Other Unspecified Eating disorder

Age at diagnosis: _____

Other psychiatric diagnosis:

☐ With comorbid psychiatric diagnosis ☐ Without comorbid psychiatric diagnosis

☐ Mood Disorder:_____

☐ Borderline Personality Disorder ☐ Safety concern

☐ Anxiety ☐ Self harm ☐ Suicidal ideation

☐ Other/Please specify:_____

Other medical diagnosis (please specify): _____

Allergies:

☐ Known allergies _____ ☐ No known allergies

Symptoms:_____

*Food allergies: Medical documentation must be provided to support specific food allergies.

Menstruation History: ☐ Normal

☐ Primary amenorrhea

☐ Secondary amenorrhea (no vaginal bleeding >3 months)

Date of last menstrual period (M/D/Y):_____

Medication History

Current medication(s)		
Medication name	Dosage	Reason for starting
Past medication trials		
Medication name	Dosage	Reason for stopping

****Please include all prescribed medication, over the counter medications, vitamins and supplements.**

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EATING DISORDER SYMPTOMS & BEHAVIOURS

Mild = a few times/month; moderate = weekly to several times a week; severe = daily

Symptom/behaviour	Past	Current	Severity of symptoms/behaviours
Restriction	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Bingeing	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Purging	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Dysfunctional Exercise	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Laxative use	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Ipecac use	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Temperature control	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Rumination	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Chewing & spitting food	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Meal Time Behaviours (Hiding/ Smearing/ Crumbling/ Wiping)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Night eating	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Selective eating	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
Other :_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe

EATING DISORDER TREATMENT HISTORY

Inpatient and/or Outpatient Eating Disorder Treatment:
Total number of inpatient eating disorder admissions: _____
☐ Currently admitted and planning to discharge home

Total number of outpatient eating disorder attempts:_____
☐ Currently in outpatient treatment
☐ Has received past outpatient treatment

Date	Facility	Reason for admission	Degree of success	Duration

****PLEASE INCLUDE THE FOLLOWING MEDICAL RECORDS WITH REFERRAL:**

1) **Growth charts**
2) **Discharge summaries from any hospitalizations related to eating disorder**

☐ I acknowledge this client is medically stable at the time of referral. I agree to provide medical monitoring to my client regularly for the duration of the Kinark outpatient eating disorder program.
Name of Referring Doctor/NP: _____
Signature of Referring Doctor/NP: _____

Phone #:_____ Fax #: _____Address:_____