Eating Disorder Triage Information

Patient Name:_____ **Patient D.O.B.**(Day/Month/Year):_____

Physician Name: _____ **Private Phone:** _____

For the referral to be considered complete and eligible for triage, the following **must** be enclosed. Missing information will delay the triage of this consultation request.

- **Growth curve/growth history**
- **ECG**
- **Bloodwork**
- **Child and Youth Psychiatric and Mental Health Services Intake Form**

Current weight: _____ Date: _____
Current height: _____ Date: _____
Current BMI: _____

Pulse Lying: ____Pulse Standing: ____ Date: _____
BP Lying: _____BP Standing: _____ Date: _____
Temperature: _____

Eating Disorder Behaviours:

Restricting _____ (1 - mild to 5 - severe)
Approximate number of calories per day _____
Binging (x per week) _____
Purging (x per week) _____
Exercising (hours per day) _____
Other (laxatives, diuretics, emetics, diet pills, other)_____

Symptoms:

Low energy: _____
Presyncope/syncope: _____
Amenorrhea: _____ Date of last menstrual period: _____
Hematemesis: _____

Please include the following lab work: CBC, ESR, lytes, Mg, Phos, ionized Ca, TSH, and Urinalysis

Level of family support: _____ (1 – low to 5 – high)

Please include any other sources of concern that would assist us in triaging the severity of your referral:

_____

_____

Please fax this document along with the **Mental Health Intake Form** to CHEO Mental Health Intake at 613-738-4235.

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