

EATING DISORDER CARE REFERRAL FORM

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Eating Disorder Care

Please accept this referral for the below noted patient:

Name: _____

DOB: _____

Contact Person: _____

Contact Telephone Number: _____

Behaviours of Concern:

- Food restriction
- Intentional vomiting
- Over-exercising
- Recent weight loss
- Fear of weight gain
- Other (laxatives, diuretics, emetics, diet pills, etc.)

Notes:

Referring Clinician: _____

Date: _____

FAX COMPLETED REFERRAL TO 1-844-430-0206