The Ottawa Hospital | L'Hôpital d'Ottawa

ASSESSMENT FOR EATING DISORDERS PROGRAM

Date of Referral : _____

Patient's Name: _____
First Middle Last

Address: _____
Street Address Apartment/ Unit #

_____
City Province Postal Code

Telephone Number: **Home:**(___)_____Business: ( ) _____

Sex: Female ☐ Male ☐ Title: Mr. ☐ Mrs. ☐ Miss ☐ Ms.☐ Other: ☐

D.O.B.: _____**Health Card Number:**_____**Version Code:**_____

Other contact Person: _____
Name Relation to Patient Telephone Number

PRESENTING PROBLEM(S) 1. _____

2. _____

3. _____

Current Weight:_____pounds (or)_____kilograms

Height:_____feet/inches (or)_____centimetres

WEIGHT CONTROL METHODS

	No	Yes	FREQUENCY Per Day	Per Week
Food Restriction				
Binge Eating				
Vomiting				
Laxatives				
Diuretics				
Ipecac				
Diet Pills				

RESULTS OF RECENT LAB WORK:

Potassium:_____Haemoglobin:_____

EKG:_____

MEDICATIONS:

Prescribed: _____

Non-prescribed:_____

REFERRING PHYSICIAN:_____
Full name (please print or type)

Address:_____
Street Address **Suite/Apt #**

_____
City **Province** **Postal Code**

Business:_____ **Physician #**_____
For OHIP billing

Additional Therapist (s):_____

Address:_____
Street Address **Suite/Apt #**

_____
City **Province** **Postal Code**

Business:_____

PLEASE FAX OR MAIL FORM TO:

Office of **Dr. H. Bissada, Director**
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Ottawa Hospital, General Campus
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K1H 8L6

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