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**
**Regional Centre for the Treatment of Eating Disorders**
**Ottawa Hospital, General Campus**
**Room 4428, Box 400**
**501 Smyth Road**
**Ottawa, ON**
**K1H 8L6**

**TEL: 613-737-8042**
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