Alberta Health Services

Eating Disorder Program Physician Referral

Last Name	First Name
Birthday *(yyyy-Mon-dd)*	
Gender	
PHN #	

Please fax form to **403-955-3066**. If you have any question with regards to this referral please call 403-955-7700 and the secretary will direct your call to the appropriate staff member.

To all Referring Physicians

- **Please complete the referral form in its entirety as outlined otherwise it will not be accepted as complete.**
- If this referral is accepted, you will receive a lab requisition form outlining the **required investigations** for completion **prior** to the patient accessing care.
- It is our expectation that the referring Physician remain involved throughout the treatment process as the Eating Disorder Program is a specialized resource that works in collaboration with the referring physician.

Date *(yyyy-Mon-dd)*			
Telephone numbers where messages of a confidential/medical nature may be left			
Home	Work	Cell	
Parent's/Guardian's Name *(if patient is under 18 years of age)*			
Mother Name	Phone Home	Phone Work	Cell
Father Name	Phone Home	Phone Work	Cell
Guardian Name	Phone Home	Phone Work	Cell

Presenting Problems

☐ Anorexia Nervosa ☐ Bulimia Nervosa ☐ Eating Disorder Symptoms, diagnosis unclear

Orthostatic Vital Signs *(Pt. should be lying down for 5 minutes and then standing for 2 minutes when taking vital signs)*			
Lying BP	Pulse	Standing BP	Pulse
Current Weight	Current Height	BMI	

Medical Problems/Concerns

Allergies	**Current Medications**

Amenorrhea ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No	Postpartum ☐ Yes ☐ No If ***Yes*** how many weeks? _____	Diabetes ☐ Yes ☐ No

Referring Physician Name	Referring Physician Stamp
Address	
Phone / Fax	
PRACID No. *(required)*	
Signature	