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| **Date**:       | **Health Card#**       | **Version**:       |
| **Legal Name (on health card)**:      **Preferred name:**       | **Gender**: [ ]  M [ ]  F [ ]  OtherPreferred pronoun:      /      | **Marital Status**:       |
| **Mailing Address**:       | **911 Address**:       |
| **Postal Code**:       | **Email address**:      @      |
| **Correspondence accepted**:Mail [ ]  Yes [ ]  No Email: [ ]  Yes [ ]  No | **Date of Birth**:      /     /      DD / MM / YYYY |
| **Telephone Numbers** (Primary):      **Messages can be left?** [ ]  Yes [ ]  No | (Secondary):      **Messages can be left?** [ ]  Yes [ ]  No |
| **Substitute Decision Maker**:        | **Relationship**:       |
| **Address:**       | **Telephone Number**:       |
| **Emergency Contact**:        | **Relationship**:       |
| **Address:**       | **Telephone Number**:       |
| **Primary Care Provider:**      **Psychiatrist:**      **Other Service Providers:**       | **Phone Number:**      **Phone Number:**      **Phone Number:**       |
| **Previous client of our program**? [ ]  Yes [ ]  No | **How long ago**?  |
| **Allergies:** **[ ]  Yes No** **[ ]  If yes, specify:**       |
| **Are there any barriers to accessing service?** [ ]  Yes [ ]  No : **If yes, specify:**(Language, communication, physical, visual etc.)  |
| **Referral Source**:        | **Agency**:       |
| **Phone:**       | **Fax #:**       |
| **If you are referring an adolescent, parent/guardian information must be provided and they must be aware of the referral and advised their participation in treatment is required.**Parent/Guardian:       Telephone #:       Aware of referral? [ ]  Yes [ ]  No |
| **Presenting Problem:** [ ]  Bulimia Nervosa [ ]  Anorexia Nervosa [ ]  Binge Eating Disorder[ ]  Other Eating Disorder [ ]  Concern with disordered eating |

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| **Eating Disorder Behaviours** (please check all that apply) |
| **Behaviour**  | **Frequency # per day** | **# days per week** |
| Binge Eating: [ ] Vomiting [ ] Laxative Use [ ] Diet Pills [ ] Diuretics [ ] Excessive Exercise [ ] Food Restriction [ ]  |                                    Estimated daily caloric intake:       |                                     |
| **Agency and School-Based Referral:**Has the primary care provider been notified of the referral?      Has an appointment with primary care provider been scheduled?       |
| **\*Huron Outreach Eating Disorders Program does not provide medical monitoring\***Primary Care Provider Physical Examination Findings:       |
| Plan of Care of Monitoring and Treating:       |
| Current Weight:       Height:       BMI:      If underweight please identify goal weight.      How much weight has individual lost over what period of time?       |
| **Other Mental Health Diagnoses:** |
| **Are other clinicians / services providing counselling?**:       |
| **Current safety factors: Assess and check all that apply below and provide details.**[ ]  Passive suicidal thoughts [ ]  Active suicidal thoughts [ ]  History of suicide attempt[ ]  Substance use [ ]  Thoughts to harm others [ ]  History of violence/aggression[ ]  Current intentional self-harm behaviours [ ]  Behaviour influenced by hallucinations/delusions **Other:**      **Details:**  |
| **Other Psychosocial Issues:**[ ]  Marital/custody [ ]  Abuse [ ]  Financial [ ]  Housing [ ]  Work[ ]  Situational Crisis [ ]  Grief/Loss [ ]  Charges Pending [ ]  On Trial **Are there any safety risks, past charges, episodes of harm towards others, or property damage that staff should be aware of in delivering services?** [ ]  Yes [ ]  No **If yes**, **specify:**  |
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