BridgeCross
Caring Treatment of Eating Disorders

PROFESSIONAL REFERRAL

Date Submitted:

DOCTORS' REFERRAL QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient's Name (last, first):	
☐ M ☐ F	DOB (mm/dd/yyyy):
Name of Parents:	
Family Heritage:	Religious Beliefs:
Family Doctor:	

FAMILY PHYSICIAN

Referring physician:	
Address:	
Telephone(s):	
Fax:	Email:
Date of last physical exam:	

DIAGNOSIS

Residential Program: ☐ Yes ☐ No	Outpatient Program: ☐ Yes ☐ No

HISTORY OF EATING DISORDER

(age at onset, precipitating factors, weight control methods, current treatments including medications and feeding tubes, etc)

PREVIOUS TREATMENT FOR ANY EATING DISORDER

(list hospitalizations, day treatment or outpatient therapy)

	Hospital	Specialized Eating Disorder Unit	Dates In Program:
1		☐ Yes ☐ No	
2		☐ Yes ☐ No	
3		☐ Yes ☐ No	
	Day Tratment Program:		Dates In Program:
1		☐ Yes ☐ No	
2		☐ Yes ☐ No	
3		☐ Yes ☐ No	
	Outpatient Program		Dates In Program:
1		☐ Yes ☐ No	
2		☐ Yes ☐ No	
3		☐ Yes ☐ No	

PAST MEDICAL HISTORY

Any problems at birth or in prenatal period?

Any other serious medical/surgical problems?

OTHER CURRENT/PREVIOUS PSYCHIATRIC PROBLEMS:

Suicidal behaviour	☐ Yes ☐ No	Depression	☐ Yes ☐ No
ADD	☐ Yes ☐ No	Borderline Personality Disorder	☐ Yes ☐ No
Substance Abuse (alcohol)	☐ Yes ☐ No	History of Abuse	☐ Yes ☐ No
CAS Involvement	☐ Yes ☐ No	Trouble with Law	☐ Yes ☐ No
Self-harm behaviour	☐ Yes ☐ No	OCD	☐ Yes ☐ No
Anxiety Disorder	☐ Yes ☐ No	Conduct Disorder	☐ Yes ☐ No
PTSD	☐ Yes ☐ No	OCD	☐ Yes ☐ No
Oppositional-Defiant Disorder	☐ Yes ☐ No	Other (please specify)	

ALLERGIES

Medication Allergies

1)

2)

3)

Food Allergies

1)

2)

3)

What Allergy Testing Has Been Done?

CURRENT MEDICATIONS; (INCLUDING OVER THE COUNTER)

Rx Name	Dosage	Start Date

FAMILY HISTORY (PARENTS & SIBLINGS):

Medical:

Psychiatric:

DATA:	
Please provide copies of all previously recorded weight and heights since birth as this is very helpful in determining goal weight for patient. Copies of growth and weight charts would be ideal.	
Highest weight ever:	Age at time:
Lowest weight in past 2 years:	Age at time:

COMPLETE PHYSICAL EXAM INCLUDING:	
Weight (kg):	Height (cm)
Oral Temperature:	
Blood pressure lying:	and standing:
Pulse lying:	and standing:
Head & neck:	Chest:
Heart:	Abdomen:
Neurological:	Skin:
Musculoskeletal:	
other:	

EKG AND REPORT			
☐ CBC	☐ ESR	☐ Bun	☐ Creatinine
☐ Electrolytes	☐ Ionized calcium	☐ Calcium	☐ Fasting Glucose
☐ Total bilirubin	☐ Direct Bilirbin	☐ AST	☐ ALT
☐ Alkaline phosphatase	☐ Albumin	☐ Serum phosphate	☐ Albumin
☐ Serum phosphate	☐ Total protein	☐ TSH	☐ Total Cholesterol
☐ LDL	☐ HDL	☐ Urinalysis R&M	☐ Urine specific gravity

Are you willing to provide follow-up medical care upon discharge?

Acceptance to treatment is based on information provided from this Application for Treatment and contact either verbally and/or electronically to gather accurate information from the applicant, the family and providing medical professional. Capacity to provide treatment in the best interest of its clients is depended on accurate information sharing, with treatment team reserving the right to terminate treatment, due to inaccuracies in reporting.

Physician's Signature: