Addendum to Centralized Intake Referral Form –

Adolescent Eating Disorders DAY TREATMENT PROGRAM

*__REFERRAL SOURCE__: The adolescent and parents must agree with the referral and sign below.
If the referral is incomplete within 30 days of receipt, the referral will close.

PATIENT DEMOGRAPHIC INFORMATION

Patient Legal name:	**Date of birth (M/D/Y):** **Age:**	**Gender:** ☐Female ☐Male ☐Other: _____	**Grade:**

REFERRAL SOURCE INFORMATION

Referring entity:	**Name of person completing this referral:**	**Referral date (M/D/Y):**

COMMITMENT FROM REFERRAL TEAM AND PRIMARY CARE PHYSICIAN (if different)

Follow up services:	☐ **Referring Program or Physician agrees to provide appropriate follow up services within 7 days of when patient is discharged from Day Treatment.**
Primary Care Physician (PCP) or Nurse Practitioner	☐ PCP/NP must assess patient no more than 1 week prior to patient's start date in day treatment to ensure medical stability. PCP/NP must continue to assess patient on a regular basis while patient is in day treatment program and agree to maintaining medical care for the patient post discharge from the day treatment program.
Discharge planning	☐ Referral source agrees to participate and assist in discharge planning check-ins with treatment team to ensure a smooth transition/discharge
Signature of referral source:	_____
Signature of referring Physician and/or Team	

CONSENT TO REFERRAL –
MUST BE COMPLETED BY BOTH THE PATIENT & PARENT(S)/CAREGIVER(S)

PATIENT: I agree to:

☐The referral to the day treatment eating disorder program for myself

☐Participate in individual, group and family (with parent(s)/ caregiver(s)) therapy sessions

☐Have my parent(s)/caregiver(s) provide me with daily, in-person meal support at dinnertime at home during program days and for 3 meals and 2 or 3 snacks daily when not in the program.

If offered a spot within 14 days, would you accept it? ☐Yes ☐No

Patient name (printed):

_____

Signature of patient:

_____

PARENT(s)/caregiver(s): I agree to:

☐The referral to the Eating Disorder day treatment program for my child

☐Participate in weekly family therapy sessions with my child

☐Participate in weekly in-person meal support with my child

If offered a spot within 14 days, would you accept it? ☐Yes ☐No

Parent(s)/caregiver(s) names (printed):

_____

_____

Signature(s) of parent(s)/caregiver(s):

_____

_____

Best numbers to reach parents/ caregiver(s) at:

_____

_____

Parent(s)/ caregiver(s) emails:

_____

PATIENT'S GOALS OF ADMISSION

Goal #1:	
Goal #2:	

Goal #3:	

DIAGNOSTIC and MEDICATION INFORMATION

Eating disorder diagnosis:	☐ Anorexia Nervosa; Subtype: ☐ Restrictive eating ☐ Binge-purge ☐ Bulimia Nervosa ☐ Avoidant Restrictive Food Intake Disorder (ARFID) ☐ Other Specified Feeding or Eating Disorder
	Age of first symptoms:
Other Co-morbid Psychiatric diagnoses:	☐ Without comorbid psychiatric diagnosis
	☐ With comorbid psychiatric diagnoses (please specify) Mood Disorder: Anxiety Disorder: OCD/OCPD: Affect Regulation Disorder: Other/Please specify:
	Interventions being utilized to treat these co-morbid conditions-- Please submit on separate document with referral
Medical diagnosis:	☐ No history of medical diagnoses/problems
	☐ History of medical diagnoses—Please specify and include more details on separate document with referral Diagnoses: Responsible PCP/ Specialist(s) and contact information:

Medication:

Current medication(s)

Medication name	Dosage	Reason for starting

Past medication trials

Medication name	Dosage	Reason for stopping

Allergies:	☐ No known allergies
	☐ Known allergies Symptoms: *Food allergies: Medical documentation must be provided to support specific food allergies.

HEIGHT & WEIGHT AND CURRENT FEEDING NEEDS

Height & Weight:	Current **Weight**: _____kg / _____lb Current **Height**:	Date weight & height recorded (M/D/Y):
	Estimated Wellness weight: _____ kg / _____ lb Method for determining target weight:	
	Current % of wellness weight (formula: current weight/ wellness weight x 100):	
	Serial Weights, Height and Growth chart to be submitted in separate document with referral	
Current feeding needs:	Patients must be consuming all nutrition in solid food and/or supplements Amount of required nutrition consumed in food: Amount of nutrition consumed in supplements:	

EATING DISORDER TREATMENT HISTORY – Attach any available documents or summary

INPATIENT eating disorder treatment:

Total number of inpatient eating disorder admissions: _____

☐ Currently admitted and planning to discharge home to outpatient or day treatment

Dates of admission	Facility	Reason for admission	Degree of progress	Duration

RESIDENTIAL Eating Disorder Treatment

Eating disorder DAY TREATMENT:

Total number of day treatment attempts (any day treatment program): _____

☐ Completed day treatment in the past

☐ Attempted day treatment but unable to complete – describe why:

☐ No day treatment completed due to lack of local availability or lengthy waitlist

☐ No day treatment completed although available – describe why:

Date of treatment	Facility	Services received	Degree of progress	Duration

OUTPATIENT eating disorder treatment:

Total number of outpatient treatment attempts: _____

☐ Currently in outpatient treatment

☐ Has received past outpatient treatment

☐ No adequate outpatient ED treatment completed due to lack of local availability or lengthy waitlist

☐ No prior outpatient ED treatment completed although available – describe why:

Date of treatment	Facility	Services received (education, FBT, MFT, therapy, etc.)	Progress?	Duration

PSYCHIATRIC TREATMENT HISTORY NOT LISTED ABOVE – Attach additional history if needed

INPATIENT PSYCHIATRIC treatment (not related to eating disorder):

Total number of inpatient psychiatric admissions: _____

☐ Currently admitted and planning to discharge home to other treatment (describe):

☐ Currently admitted and unable to discharge home

Date of admission	Facility	Reason for admission	Degree of success	Duration

PSYCHIATRIC OUTPATIENT/day treatment and/ or other psychiatric treatment:

Describe any outpatient or day treatment psychiatric treatment history below:

Date of treatment	Facility	Services received	Degree of success	Duration

EATING DISORDER SYMPTOMS & BEHAVIOURS

Mild = a few times per month; moderate = weekly to several times a week; severe = daily to multiple times a day

Symptom/behaviour list	Past- time frame	Current	Severity of symptoms/behaviours
Restriction	☐ Yes ☐ No	☐ Yes ☐ No Describe:	☐ Mild ☐ Moderate ☐ Severe
Bingeing	☐ Yes ☐ No	☐ Yes ☐ No Describe:	☐ Mild ☐ Moderate ☐ Severe
Purging	☐ Yes ☐ No	☐ Yes ☐ No Describe:	☐ Mild ☐ Moderate ☐ Severe
Excessive Exercise	☐ Yes ☐ No	☐ Yes ☐ No Describe:	☐ Mild ☐ Moderate ☐ Severe
Laxative use	☐ Yes ☐ No	☐ Yes ☐ No Describe:	☐ Mild ☐ Moderate ☐ Severe
Vital Sign Abnormalities	☐ Yes ☐ No	☐ Yes ☐ No Describe:	☐ Mild ☐ Moderate ☐ Severe
Swallowing Difficulties, GERD or Rumination	☐ Yes ☐ No	☐ Yes ☐ No Describe:	☐ Mild ☐ Moderate ☐ Severe
Chewing & spitting food	☐ Yes ☐ No	☐ Yes ☐ No Describe:	☐ Mild ☐ Moderate ☐ Severe
Meal Time Behaviours (Arranging, Hiding, Smearing, Spilling, etc.)	☐ Yes ☐ No	☐ Yes ☐ No Describe:	☐ Mild ☐ Moderate ☐ Severe
Refeeding Syndrome	☐ Yes ☐ No	☐ Yes ☐ No Describe:	☐ Mild ☐ Moderate ☐ Severe
Other (please comment):	☐ Yes ☐ No	☐ Yes ☐ No Describe:	☐ Mild ☐ Moderate ☐ Severe

BEHAVIOURAL SYMPTOMS – AGGRESSION, SELF-HARM, & SUICIDAL BEHAVIOURS

Mild = a few times per month; moderate = weekly to several times a week; severe = daily to multiple times a day

Symptom/Behaviour list	Past- time frame	Current	Severity of behaviours
Aggression toward others	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
	Describe:		
	Context:		
Self-harm	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
	Describe:		
	Context:		
Suicidal Ideation, ideation and/or plan	☐ Yes ☐ No	☐ Yes ☐ No Describe:	☐ Mild ☐ Moderate ☐ Severe
Suicide Attempts	☐ Yes ☐ No	☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe
	Number of Attempts & Dates:		
	Methods:		

	Context:
FAMILY SUPPORT & COMMITMENT TO TREATMENT	
Living arrangements:	Patient lives with: Describe: Does patient have siblings? ☐ Yes ☐ No Describe:
Legal custody arrangements:	Describe:
Family/caregiver/ friend(s) support:	Describe the patient and family/caregiver/ friend relationship and dynamics, including siblings:
	Describe how the family/caregiver/ friend provides support to their child and any barriers or difficulties that impact care:
	Please describe family/caregiver commitment to day treatment and any barriers or difficulties that impact care:
MEDICAL INFORMATION—Pls submit any laboratory and/ specialist reports with referral	
Menstrual function:	☐ Normal & regular ☐ Primary amenorrhea ☐ Secondary amenorrhea (no vaginal bleeding >3 months)
	Date of last menstrual period (M/D/Y):
ECG: ***Must be completed within the past 4 weeks before the referral. If wait time exceeds 1 month for the program, the patient will be required to be repeated within 4 weeks prior to admission**	Date of most recent ECG (M/D/Y):
	☐ Normal ☐ Bradycardia ☐ QTc: ☐ Other abnormalities
	Please list abnormalities:
Bloodwork: *** Must be completed within the past 4 weeks before the referral. If wait time exceeds 1 month for the program, the patient will require to be repeated within 4 weeks prior to admission**	Date of last bloodwork (M/D/Y):
	PLEASE ATTACH COPY OF LABS RESULTS: CBC and diff, electrolytes (calcium, magnesium, phosphate), glucose, urea, creatinine, AST, ALT, GGT, alkaline phosphatases, albumin, Vit b12, TSH, Ferritin
	☐ Normal lab results ☐ Abnormal lab results
	Please list abnormal results:
Heart Rate: *** Must be completed within the past 7 days before the referral. If wait time exceeds 1 month for the program, the patient will require to be repeated within 7 days prior to admission**	Date information was obtained (m/d/y):
	Heart rate daytime: _____ Heart rate nighttime: _____ Lying: HR_____beats/min Standing:_HR_____beats/min Orthostatic heart rate change: _____
	☐ < 50 beats/min or orthostatic rise >10 ☐ 50-60 beats/min ☐ >60 beats/ min

Blood pressure: *** Must be completed within the past 7 days before the referral. If wait time exceeds 6 months for the program, the patient will require to be repeated within 7 days prior to admission**	Date information was obtained (m/d/y):
	Lying: _____/_____ mm/hg Standing: _____/_____ mm/hg
	Blood Pressure must be > 80/50 and orthostatic drop < 20 systolic, < 10 diastolic
Temperature at time of referral:	Celsius:
Vaccinations:	Please submit most recent copy of up to date vaccinations, including **COVID**

REFERRAL CRITERIA AND PROCESS

Referral Acceptance will include a three-part Assessment:

1. Initial Stage: Once all the information is received, the Ontario Shores Day Treatment team will review the referral to ensure that the patient meets the criteria below.
2. Second Stage: Should the referral meet initial criteria; the adolescent and parent(s) will participate in an outpatient interview by one of the OS Day Treatment staff conducted via OTN or telephone. If further information obtained in this interview requires clarification, the staff will contact the referral source. At that time, a decision will be made regarding referral tentative acceptance or denial.
3. Third stage: The patient will attend the day treatment program for an assessment week (Monday thru Thursday). Adolescent and parents who participate appropriately and continue to meet the criteria thru this assessment period will be fully accepted for the remainder of the 16-week program.

ACCEPTANCE CRITERIA:

- The adolescent must be between 12 years of age and 17 years, 8 months of age. This means that the patient can only be admitted to the program at least four months prior to their 18th birthday because they cannot continue in the program after they turn 18.
- Referral must be made by a physician or Nurse Practitioner (e.g. Psychiatrist, Paediatrician, Primary Care Provider, etc). If the referral is initiated by a treatment program, therapist, patient or parent it still must be done in concert with a Physician or NP who will sign the referral form
- The adolescent and parent(s) must be willing to actively engage in day treatment.
- Any current treatment should continue until admission.
- Referring health care provider, agency and Primary Care Provider are able to commit to provide appropriate follow-up after the adolescent has completed or discharged from the Ontario Shores day treatment program. If a higher level of care is needed they should assist us in finding resources
- Referring team will sign the appropriate **collaborative service agreement** that is attached to this referral.

  Please note:
  - If this referral is coming from a **Acute Care Medical facility,** Please complete the Collaborate Service Agreement for Referrals from Acute Care Medical facilities
  - If this referral is coming from a **Psychiatric acute care setting,** Please complete the Collaborative Service Agreement for Referrals from Acute Care Medical facilities
  - If this referral is coming from an **outpatient setting** (e.g., outpatient program), please complete the Collaborative Service Agreement for Referrals from an Outpatient Treatment
  - If this referral is coming from a **primary care provider or Community Psychiatrist** (e.g., NP or Physician), please complete the Collaborative Service Agreement for referrals from a Primary Care Provider/ Community Psychiatrist/ Nurse Practitioner

REFERRAL EXCLUSION CRITERIA:

- Adolescent and/ or family has not signed the referral agreement
- Adolescent and/or family are not clearly committed to treatment, disagree on treatment goals set by the program, or not wanting or not able to consistently attend program
- Involuntary and/or Incapable
- Engagement in self harm that is treatment interfering (e.g., self harming in front of other patients, self harm requiring any medical intervention etc.)
- Suicidal ideation with a plan and/or intent, or recent hospitalization for such
- Referral sources not agreeing to provide appropriate follow up services, when required, within an agreed upon timeframe of discharge from Ontario Shores. Please see Discharge Service Agreement attached, sign and send with the referral
- Those diagnosed with Binge eating disorder alone
- Significant and severe borderline personality symptoms
- Not able to consume adequate nutrition orally (minimum of 50% in solid food, remainder in nutrition supplements)
- Not ready and/or willing to participate in active meal and snack support at a table with peer group and day treatment staff
- Not ready and/or willing to participate in active meal and snack support at a table with peer group and day treatment staff

• Requires enteral feeding (NG tube, G-tube etc.)
• Program may not be helpful for those who are not cognitively able to participate in their care and the treatment program
• **Patient not medically stable**

MEDICAL CRITERIA:

Must consistently meet the Criteria below

- At least 80 % weight restored at time of referral and admission to Day Treatment
- Consistently meeting medical stability requirements (see below). Each case will be reviewed by the receiving physicians prior to admission
- Patients must have a heart rate >50 bpm during the daytime and >45 at nighttime
- Orthostatic heart rate change must be <35 bpm and asymptomatic (no recent syncopal episodes)
- Blood Pressure must be >80/50 and orthostatic drop is <20
- In some cases (e.g. high level athletes) may be exempted from these VS criteria if there is proof of baseline bradycardia/hypotension prior to onset of eating disorder
- Body temperature > 35.6C
- No significant Electrolyte disturbance-(hypokalemia, hypoglycemia, hyponatremia, hypophosphatemia)
- No current acute medical complications: syncope, seizures, cardiac failure, renal failure
- Not pregnant
- No esophageal tears
- No significant abnormalities in ECG (ECG within last 4 weeks)
- No cardiac arrhythmias or prolonged QTc (unless cleared by a cardiologist)
- No hematemesis

GROUNDS FOR EARLY DISCHARGE

- Lack of ongoing patient engagement and participation
- Lack of ongoing parent engagement and participation
- Not able to be safe
- Not able to cooperate with nutrition plan
- Not able to follow the rules and requirements of the program including no interaction with other patients outside of program (details will be provided when accepted to program)
- Needs of co-morbid disorder exceed the capacity of the program to treat or interfere with Eating Disorder treatment
- In some cases we may recommend admission to the inpatient Eating Disorder Unit for further stabilization

Ontario Shores
Centre for Mental Health Sciences

Collaborative Service Agreement for Referrals from Acute Medical Facilities

You and your facility agree to work collaboratively with Ontario Shores to:

- Repatriate patient to your facility if the patient becomes medically unstable/ NG dependent as Ontario Shores is not an acute care facility and cannot provide this level of care.

- Obtain follow up services from your organization when required. We are requesting that the follow up with your team occur within 7 days of discharge.

The following measures will be put into place to support a successful discharge for the patient and their family:

- With consent from the client and their parent/ legal guardian, telephone and/or OTN /zoom consultation with the referring team and Ontario Shores will occur throughout the admission to provide updates. These meetings will include recommendations for discharge planning.

- Provide the patient, parent/legal guardian and the receiving care team with an update on psychiatric and medical interventions, progress made during the inpatient residential stay, issues that will need to be addressed post-discharge from Day Treatment Program, and education on specific symptom management strategies that have been successful with the patient while at Ontario Shores. Please provide name, phone, and email contact for your care coordinator.

  _____

This letter serves as your understanding and agreement that:

- The patient will be accepted back to your Eating Disorder Out Patient Program within 7 days of discharge from Ontario Shores.

- Your organization will work collaboratively with Ontario Shores to arrange an acute care medical bed should a patient become medically unstable or NG dependent _____ (please initial)

_____(Director)
Name & Title (print and signature)
_____(Hospital/referral source) Date: _____

I have the authority to bind _____(Hospital name/referral source) as the delegated signing authority to govern and oversee the operation of this Agreement.

_____(Psychiatrist/Physician/ NP)

Name & Title (print and signature)
_____(Hospital /referral source) Date: _____

I have the authority to bind _____ (Hospital name/referral source name) as the delegated signing authority to govern and oversee the operation of this Agreement.

Ontario Shores
Centre for Mental Health Sciences

Collaborative Service Agreement for Referrals from an Outpatient Treatment Service

You and your organization agree to work collaboratively with Ontario Shores to:

- Obtain follow up services from your organization when required. We are requesting that the follow up with your team occur within 7 days of discharge from Day Treatment Program.

The following measures will be put into place to support a successful discharge for the patient and their family:

- With consent from the client and their parent/ legal guardian, telephone and/or OTN /zoom consultation with the referring team and Ontario Shores will occur throughout the admission to provide updates. These meetings will include recommendations for discharge planning.

- Provide the patient, parent/legal guardian and the receiving care team with an update on psychiatric and medical interventions, progress made during the inpatient residential stay, issues that will need to be addressed post-discharge from Day Treatment Program, and education on specific symptom management strategies that have been successful with the patient while at Ontario Shores. Please provide name, phone, and email contact for your care coordinator.

  _____

This letter serves as your understanding and agreement that:

- The patient will be accepted back to your Eating Disorder Out Patient Program within 7 days of discharge from Ontario Shores.

_____(Director)
Name & Title (print and signature)
_____(Organization/referral source) Date: _____

I have the authority to bind _____(Organization name/referral source) as the delegated signing authority to govern and oversee the operation of this Agreement.

Ontario Shores
Centre for Mental Health Sciences

Collaborative Service Agreement for Referrals from a Primary Care Provider/ Community Psychiatrist/ Nurse Practitioner

You and your organization agree to work collaboratively with Ontario Shores to:

- Continue following the patient and arrange a follow up appointment within 7 days of discharge.

The following measures will be put into place to support a successful discharge for the patient and their family:

- With consent from the client and their parent/ legal guardian, telephone and/or OTN /zoom consultation with the referring team and Ontario Shores will occur throughout the admission to provide updates. These meetings will include recommendations for discharge planning.

- Provide the patient, parent/legal guardian and the receiving care team with an update on psychiatric and medical interventions, progress made during the inpatient residential stay, issues that will need to be addressed post-discharge from Day Treatment Program, and education on specific symptom management strategies that have been successful with the patient while at Ontario Shores. Please provide name, phone, and email contact for your care coordinator.

  _____

This letter serves as your understanding and agreement that:

- The patient will be accepted back to your Eating Disorder Out Patient Program within 7 days of discharge from Ontario Shores.

_____(Director)
Name & Title (Primary care provider/ community psychiatrist/ nurse practitioner)

Signature: _____ Date: _____