

Referral Form

Child & Adolescent Eating Disorders Program



WRHN

Waterloo Regional
Health Network

Please complete all the information below and

FAX: (519) 745-7649

Referrals are only accepted for the geographical catchment of Kitchener-Waterloo region (including Wellesley, Wilmot, and Woolwich).

Referrer Information

Referring Provider:

Phone:

Fax:

Billing Number:

Family Physician *if different from above*:

Incomplete referrals will NOT be accepted. Please complete all information and attach growth chart.

Patient Information

Last Name:

First Name:

Date of Birth (yyyy/mm/dd/):

Gender:

Health Card Number:

Address:

Caregiver Names:

Relationship:

Phone:

Email:

Caregiver Aware of Referral?

Anthropometrics

*****If HR is <50, or Postural >30, contact pediatrician on call at WRHN**

Current Weight (kg)

Lowest Weight & Date:

Heart Rate Laying 2 min:

Blood Pressure Lying:

Age of Menarche (if applicable):

Growth Curve Attached (required): Y/ N

Current Height (cm):

Highest Weight & Date:

Heart Rate Standing 2 min:

Blood Pressure Standing:

Last Menstrual Period:

Recent Lab Work Attached: Y/N

Eating Disorder Specifics

AN-R AN-BP BN OSFED

ARFID - *Please circle specifics: Sensory / Lack of Interest / Fear Adverse Consequences*

Briefly describe frequency/details of symptoms, and/or attach clinic note(s):