

Parent or Guardian Email: _____

PROGRAM & URGENCY

Referral To: (select all that apply)

- Pediatric/Adolescent Medicine consult and follow-up if needed Dr. Rachel Barrett or Dr. Samantha Martin
- Nurse Practitioner Consultation

Referral Reason and Other Information – Please provide as much detail as possible:

Has your patient received any Eating Disorder or mental health diagnoses, and if so, when and from whom?

Has your patient been hospitalized as a result of their eating-related concerns? If so, please include the program details, approximate dates, and any ongoing ED-related care they're receiving:

Please send via fax the following supporting documents needed in order to process your referral:

- Childhood growth charts.
- Any investigations performed in the last year (bloodwork, ECG, imaging).
- Relevant physician consultation notes (both medical and psychiatric).
- Hospitalization consult and discharge notes

PLEASE FAX ADDITIONAL DOCUMENTS TO (647) 277-1225

Reminder: Please include patient's name on your faxes.