TPWG · MD

Physician's Referral Form

REFERRING PHYSICIAN

Physician's Name: ________________ ________________________
First Last

Physician's Email: ___________________________

Physician's Billing Number: ____________________

Physician's Address:

____
Street Address

____
Address Line 2

________________________ ___________________________
City Province

____
Postal Code

Physician's Phone: __________________ Physician's Fax: ________________

PATIENT INFORMATION

Patient's Name: __________________ ________________________
First Last

Date of Birth (DD/MM/YYYY): ___________________

OHIP Number: _____________________ Version Code: ___________________

Parent or Guardian Phone Number: _________________________

Parent or Guardian Email: ____________________________________

PROGRAM & URGENCY

Referral To: (select all that apply)

- ○ Pediatric/Adolescent Medicine Consult and follow-up if needed with: Dr. Ilana Walters, Dr. Rachel Barrett or Dr. Samantha Martin
- ○ Adolescent Psychiatry Consult with Dr. Rachel Mitchell
- ○ 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 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 (if referred for ED treatment)
- 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.