Alberta Health Services

COMMUNITY CARE PROVIDER PORTION

Last name(legal)	First name (legal)	
Preferred Name	DOB (dd-Mon-YYYY	
PHN	**ULI**	**MRN**
Administrative gender ☐ Male ☐ Female ☐ Non-binary/prefer not to disclose		
Please fax this form to **(403) 955-3066**. If you have any questions with regards to this referral, please call **(403) 955-7700.**		

SANDSTONE RECOVERY CENTRE

operated by Edgewood Health Network in collaboration with the Calgary Eating Disorder Program

External Referral

This **referral form** is for Sandstone Recovery Centre **ONLY**, if you would like to refer your client to the general Calgary Eating Disorder Program please use appropriate form https://albertareferraldirectory.ca/

- This part of the **referral form** is for community providers **ONLY**
- Providers **must** establish that the client requires **intensive services**

Date:	Referring Provider:	Referring Provider Address: Phone: Fax:	
Patient Address:		Patient Phone:	
Legal Guardian(s) *if applicable*:		Legal Guardian Phone:	Relationship:
Is the client/family willing to access a community treatment bed?		☐Yes ☐No	
Is the current community provider willing to resume care after discharge?		☐Yes ☐No	
Name of current medical provider: Phone:		Is the current medical provider willing to resume care after discharge? ☐Yes ☐No	

Clinical Information:	
How long have you been working with this client?	Please Specify:
What has prompted this referral?	
Presenting Problems: ☐Anorexia Nervosa ☐Bulimia Nervosa ☐Eating Disorder Symptoms, diagnosis unclear	
Other concurrent mental health concerns:	

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COMMUNITY CARE PROVIDER PORTION – Part 2

Please describe client's current symptoms & concerns – (use of laxatives/diuretics/diet pills, purging, excessive exercise or restriction) **please note when symptoms began**:	
Safety Concerns: ☐ Suicidal Ideation/ Homicidal Ideation ☐ Self-Harm ☐ Elopement Risk ☐ Substance use ☐ Other	Please specify: Please specify: Please specify: Please specify: Please specify:

Eating Disorder Treatment History:	
☐ Most Recent Hospital Admission(s)	Discharge Date: Length of stay: Location:
☐ Treatment Groups	Please Specify:
☐ Individual/Family therapy	Please Specify:
Please briefly describe your current work with the family/client:	

Treatment Goals (check all that apply):

☐ Weight restoration/prevention of further weight loss

☐ Meal support/ Nutrition rehabilitation

☐ Family Respite

☐ Decrease ED behaviors

☐ Prevent hospitalization

☐ Other:

MEDICAL PORTION

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PHN	**ULI**	**MRN**
Administrative gender ☐ Male ☐ Female ☐ Non-binary/prefer not to disclose		
Please fax this form to **(403) 955-3066**. If you have any questions with regards to this referral, please call **(403) 955-7700.**		

To all referring physicians and providers:

- This **referral form** is for the Sandstone Recovery Centre. **I**f you would like to refer your client to the general Calgary Eating Disorder Program, please use appropriate form https://albertareferraldirectory.ca/.
- Please complete the referral form in its entirety otherwise it will not be accepted.
- If this referral is accepted, you will receive a lab and ECG requisition form for required investigations.
- **Medical stability is a requirement to access this specialized service.**

It is our expectation that the referring physician remain involved throughout the treatment process as the Sandstone Recovery Centre is a specialized resource that works in collaboration with primary care providers and the community care team.

Date:	Referring Provider/PRACID:	Referring Provider Address: Phone: Fax:	
Patient Address:		Patient Phone:	
Legal Guardian(s) *if applicable*:		Legal Guardian Phone:	Relationship:

Reason for referral (check those that apply): ☐ Nutritional rehabilitation/meal support ☐ Weight recovery ☐ Decrease binge/purge cycle ☐ Other:	Has your patient experienced any of the following in the last 30 days? (check those that apply): ☐ Fainting, blacking out or falling ☐ Chest pain ☐ Blood in vomit ☐ Seizures ☐ Electrolyte replacements

Patient's current medical status: ☐ Stable ☐ Worsening

Current weight:	Height:	BMI:	Amount of weight loss (if applicable): Time frame weight loss occurred:
Lying BP (lying for 5 mins):	Lying Pulse:	Standing BP (Standing for 2 mins):	Standing Pulse:
Last menstrual period (if applicable):	Postpartum (if yes how many weeks):		Pregnant: ☐ Yes ☐ No
Medical Comorbidities:			Allergies: ☐ Yes ☐ No Diabetes: ☐ Yes ☐ No
Current Medications:			

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