BRIDGEPOINT
CENTER FOR EATING DISORDERS

PART B
completed by Counsellor

CONFIDENTIAL INFORMATION – COUNSELLOR REFERRAL

BridgePoint Center is a non-profit provincially approved facility that works in partnership with the Saskatchewan Health Authority. We are a part of the continuum of services offered in Saskatchewan for the treatment of eating disorders. Our intention is to create a working relationship to provide continuity of care. As such, we request that you provide the following information as part of your referral. You may be contacted should there be further information required. All information will be held in confidence. Our mutual client will be asked to sign a release of information to facilitate communication with both physician and counsellor as part of creating a home plan.

If you are referring on behalf of a client, please ensure that the client has also completed and submit Part A of the application.

Client Name: ____

How Long have you been in a therapeutic relationship with this client? ______________________________

Are you available for ongoing support after your client completes the Module? ◯ **Yes** ◯ **No** If not, why? ______________

____

Please describe the issues you and your client are currently addressing:

____

____

____

____

Please share any of your client's pertinent history (including any trauma, abuse, addiction or substance use).

____

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____

Do you support your client's choice to attend BridgePoint Center at this time? Do you have any concerns or information that we should be aware of?

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____

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____

Referring Agency	**Name**: ____________________ **Email**: ____________________ **Clinic Name/Address:**______________________________ **Phone**: ______________ **Fax**: ______________

For admission to BridgePoint, participants must be psychiatrically and medically stable.

Please review and check:

◯ I am available to participate in a 20 minute home plan conference call with BridgePoint and my client at the end of program; scheduled one day prior to discharge. I am available at the following times: _______ ______ or _______ at the following phone number: ______________.

We will contact you via email to confirm appointment times.

◯ I am not available to participate in a conference call but would like to receive follow-up documentation.

◯ Supplemental reporting or information to this referral.

Referral Signature: ______________________________ Date: ____________________

Please return: Admissions, BridgePoint Center Fax: (306) 935-2241 Email: bridgepoint@sasktel.net Phone: (306) 935-2240

www.bridgepointcenter.ca

BRIDGEPOINT
CENTER FOR EATING DISORDERS

PART C
completed by Physician

CONFIDENTIAL INFORMATION – MEDICAL STATUS & STABILITY REFERRAL FORM

If you are referring on behalf a client, please sure that the client has also completed and submit Part A of the application.

Client Name: ____ **PHN**: ____________________________

Age: _____ **Height:** _____ **Weight (if relevant):** ____ **Blood Pressure:** ____ **Pulse:**_____ **LMP:** ______ **TEMP:** ____

Provide Eating Disorder Behaviours, Diagnosis as well as other concurrent diagnoses:

____

____

____

Pertinent Past Medical History:

____

____

____

Has the client been medically unstable in last 6 months? ◯ Yes ◯ No **Provide Details:**

____

Is the client currently medically stable? ◯ Yes ◯ No **If yes, for how long**? ______________________________

Indicate any pertinent abnormalities or stability concerns:

____

____

Date of last physical:	Concerns:			
Changes in weight during the past year	◯ Gain	◯ Loss	◯ Stable	How Much:
At risk of refeeding syndrome	◯ No	◯ Yes		
Recent medication Changes	◯ No	◯ Yes	◯ Compliance concerns:	
Known substance usage/abuse/addiction	◯ No	◯ Yes	Specify:	*** CANNOT DETOX AT BRIDGEPOINT**
Medical marijuana prescription	◯ No	◯ Yes	Please attach.	
Known self-harm behaviours	◯ No	◯ Yes	◯ Past	Specify:
Seizure in last 6 months	◯ No	◯ Yes	Specify cause/Treatment:	
Diabetic	◯ No	◯ Yes	Specify Type/Treatment:	
Pregnant	◯ No	◯ Yes	# weeks/concerns:	
Sleep Apnea	◯ No	◯ Yes		
Mobility concerns/mobility devices	◯ No	◯ Yes	Participant must be able to attend to their own self care.	
Medically diagnosed allergies	◯ No	◯ Yes	Reaction:	

Pre-Admission Lab Work 2 weeks prior to admission: **PLEASE FAX TO BRIDGEPOINT CENTER (306) 935-2241**

*Bloodwork is to be reviewed by physician as part of determining stability required for admission. If physical or labs are abnormal, please indicate plan for follow-up, treatment or attach **additional notes.***

- **Routine Urinalysis**
- **Electrolytes**
- **Creatinine + eGFR**
- **Urea**
- **HbA1c**
- **Calcium**
- **Iron Levels and TIBC**
- **THYSA**
- **Liver Functions**
- **Protein Levels**
- **B12**
- **ECG (if applicable)**

Weekly bloodwork is not typically available during programming unless discussed and planned prior to programming.

Check here:

◯ I understand BridgePoint Center is **not** a medical facility and consider my patient's current medical stability status suitable for admission for residential eating disorder treatment**. I will update BridgePoint on any changes in stability prior to admission**.

Referring Agency: ◯ GP/Family Doctor ◯ Nurse Practitioner ◯ Other ____________________

Physician Name *(please print):* ______________________________ **Clinic:** ______________________________

Phone: ______________________________ **Fax:** ______________________________

Referral Signature: ______________________________ **Date:** ______________________________

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