

PART C – CONFIDENTIAL MEDICAL INFORMATION (Physician’s Referral)

(Please fill out everything except #5. Refer to #5 for further information)

BRIDGEPOINT CENTER FOR EATING DISORDERS INC., Box 190, Milden, SK, Canada, S0L 2L0 Phone: 306-935-2240 Fax: 306-935-2241

Name of Client: _____ Date: _____

Age: _____ Height: _____ Weight: _____ BMI: _____ Blood Pressure: _____ Pulse: _____

1. BridgePoint is **not** a medical facility. Please provide the following information for our nursing team.

Is the client medically stable? Check one: Yes No

If yes, how long (i.e. what length of time) **has she/he been medically stable?** _____

2. Is the client currently taking medication? Check one: Yes No

If yes, list all current medication(s), (including dosage and frequency) Use back of form if necessary.

3. Date of last physical examination: _____

4. **Provide eating disorder diagnosis and list any other diagnoses** _____

5. **The following blood work is to be done within one month of ORIENTATION start date.** BridgePoint must receive blood work lab results two weeks prior to client's arrival

_____ Hgb A 1 C	_____ Protein levels
_____ ECG (If applicable)	_____ TIBC
_____ Urea	_____ Iron Levels
_____ Electrolytes	_____ Other _____

6. Provide list of food and other **allergies:** _____

7. Other relevant observations or comments that may be of assistance: _____

Name of Physician

Address

Address

Signature

Phone Number

Fax Number