NIAGARA EATING DISORDER OUTPATIENT PROGRAM

Niagara Health System – Port Colborne General Site
260 Sugarloaf Street, Port Colborne, ON, L3K 2N7
Phone: (905)378-4647 Ext. 32532 • Fax: (905)834-3002
Email: nedop@niagarahealth.on.ca
Web: www.niagarahealth.on.ca/services/eating_disorder.html

Referral Date ___/___/___

1st Appointment ___/___/___ (DD / MM / YY)

I N T A K E F O R M

Client First Name:

Client Last Name:

Date of Birth: *(DD – MM - YY)*
Must be 16 years or older

Gender: ☐ **Male** / ☐ **Female**

Last Name at Birth:

Home Phone: ( )
Cell Phone: ( )

Street Address:

City, Province:

Postal Code:

I.D. Agency When Calling: ☐ **Yes** / ☐ **No**
If no:

Referral Agency:

Referral Agent Name:

Referral Phone: **Fax:**

Health Card #: **Ver:**

HC expiry date: **Aboriginal: Y / N**

Next of Kin: **Relation:**

Next of Kin Phone: ( )

Ever Married: ☐ **Yes** / ☐ **No**

Current Marital Status:

Highest Education:

Employment: ☐**Full** ☐**Part** ☐**Looking** ☐**Not Looking**

Source of Income:

Legal Problems:

Family Doctor:

Address:

Phone: **Fax:**

Psychiatrist:

Address:

Phone: **Fax:**

Yes	No	**Visual Impairment**
Yes	No	**Hearing Impairment**
Yes	No	**Mobility/Physical Impairment**
Yes	No	**Pregnant**
Yes	No	**Gambling Problem**

☐ **Consult Note Requested**

☐ **Able to participate in group programming**

Current Problem Behaviours		**# Days in Last Month**
1.		
2.		
3.		

Physical Health

# of medical hospitalizations in past year:_____	BP Lying:
Weight in kg: _____	BP Standing:
Height in cm: _____	HR Lying:
BMI:_____	HR Standing:
	Temp:_____

Investigations done (please enclose)

1.	**CBC, electrolytes, renal function, calcium, TSH, B12**
2.	**ECG**
3.	**Other**

Substances Used

☐ **None**

☐ **Tobacco** ☐ **Alcohol** ☐ **Cannabis**

☐ **OTHER:**

Mental Health History

Yes	No	**Diagnosed – Currently**
Yes	No	**Diagnosed in Lifetime**
Yes	No	**Hospitalized – Last year**
Yes	No	**Hospitalized in Lifetime**
Yes	No	**Counselling/Support/Tx – Now**
Yes	No	**Counselling/Support/Tx in Last Year**
Yes	No	**Counselling/Support/Tx – Ever**
Yes	No	**Prescribed Medication – Now**
Yes	No	**Prescribed Medication in Last Year**
Yes	No	**Prescribed Medication - Ever**

Mental Health Diagnoses & Prescribed Meds:

Treatment Goals

Last Revised Jan 2015