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Niagara Eating Disorder Outpatient Program

`Niagara Eating Disorder Outpatient Program
Niagara Health – Port Colborne General Site
260 Sugarloaf Street,
Port Colborne, ON L3K 2N7 (map)

Phone: (905) 378-4647 ext. 32532
Fax: (905) 834-3002
Email: nedop@niagarahealth.on.ca
Web: https://www.niagarahealth.on.ca/site/eating-disorder-program

Referral to NEDOP is for consultation and management/treatment recommendations for clients age 16 and older. Referrals are accepted and reviewed prior to accessing services.
Referrals are accepted from a Primary Care Provider.

The following investigations are to be included with the referral along with height, current weight, postural vital signs and any other information helpful to the client's care.

Investigations required:

> **CBC with differential, Electrolytes, Calcium, B12, TSH, Creatinine with eGFR, ALT and an ECG**
> Other investigations are at the discretion of the family physician and results are appreciated to aid in patient care.

Repeat investigations focus on any abnormalities found on initial screening investigations with close monitoring of liver function tests, electrolytes, calcium and magnesium, as well as an ECG to check for arrhythmias and prolonged QTC. Routine physical monitoring of the client would include weight, postural vital signs, body temperature and hydration status.

Acute medical situations requiring short-term management may arise. Admission to hospital must be based on physician's individual judgement, but some admitting criteria for adults according to the APA guidelines include a weight loss of 25% in less than 6 months, heart rate less than 40 beats per minute; an arrhythmia or prolongation of the Q-T interval; a blood pressure below 90/60 or a greater than 20 millimetre postural change in blood pressure; significantly low blood sugar; a potassium of less than 2.5 mmol/L; electrolyte imbalance; hypothermia, and dehydration. Admission criteria for adolescents and children include <75-80% of ideal body weight, bradycardia, hypotension, orthostatic hypotension, dehydration, electrolyte abnormalities, arrhythmias, acute food refusal and/or any instability. Please see the APA guidelines and hospital protocols for further information.

The program offers outpatient services that are primarily group based, with some limited resources for individual counselling or psychotherapy. No inpatient services are available.
The client must be medically stable to participate in programming.

It is required that the Primary Care Provider will continue to medically monitor their patients while they are in the program. This may mean weekly monitoring, especially for adolescents, or admission to hospital as outlined above. We are available for consultation as needed.

Referrals will be made to more intensive treatment programs as needed. Information on these programs may be obtained from our clinic coordinator or found on our website (Treatment Resources).

If the patient is under 16 years of age, please refer them to McMaster Children's Hospital Fax (905)521-2349.
We no longer provide services to clients under the age of 16.

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New Port Centre
Niagara Health - Port Colborne General Site
260 Sugarloaf Street, Port Colborne, ON L3K 2N7
(905)378-4647 x32532 Fax (905)834-3002
Web: https://www.niagarahealth.on.ca/site/eating-disorder-program
Email: nedop@niagarahealth.on.ca

Patient Label

NEDOP INTAKE FORM

Client First Name:	☐ Consult Note Requested
Client Last Name:	☐ Able to participate in group programming
Current Marital Status:	Reason for referral / Duration
Date of Birth: (DD – MM - YY) ***Must be 16 years or older***	
Gender: ☐ Male / ☐ Female / ☐ _____(As you identify)	1.
Last Name at Birth:	2.
Health Card #: Version Code:	
Health Card expiry date:	3.
Address: City, Province: Postal Code:	Physical Health # of medical hospitalizations in past year: / BP Lying: / BP Standing:
Home Phone ( ) Cell: ( )	Weight in kg: / HR Lying: / HR Standing:
Can we identify our clinic when calling? ☐ Yes / ☐ No Can we leave a message? ☐ Yes / ☐ No	Height in cm:
Primary Care Provider:	BMI: / Temp:
Address:	Investigations done **please enclose results for our triage process
Referral Phone: ( ) Fax: ( )	1. **Required – CBC, electrolytes, renal function, calcium, TSH, B12** 2. **Required - ECG** 3. Other (please list)
Family Doctor (if different from PCP):	Substances Used ☐ No Substances Used ☐ Tobacco ☐ Alcohol ☐ Cannabis ☐ OTHER:
Address: City, Province: Postal Code:	Mental Health Diagnoses
Phone: ( ) Fax: ( )	Prescribed Medications
Referral Source (please indicate): ☐ Primary Care Provider ☐ Family Doctor (if different from PCP)	