VCH Eating Disorders Program
3rd Floor 2750 East Hastings
Vancouver, BC V5K 1Z9
Phone: 604-675-2531
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Vancouver Coastal Health Eating Disorders Program
PILOT- ARFID CLIENT REFERRAL

Referral Criteria:

The Eating Disorder Program services clients with eating disorders as outlined in the DSM V. We are now offering a short term pilot program for clients 12-18 years old with ARFID (Avoidant/Restrictive Food Disorders (see Page 5 for more information on diagnostic criteria). Service will include assessment and 8-20 individual sessions with a registered dietitian and clinical therapist.

- Clients must be residents of Vancouver. Client for West/North Vancouver, Sea to Sky corridor or Sunshine Coast must be referred to the North Shore Youth EDP at 604-984-5060.

- **Client must be followed by a physician (NP, family physician or paediatrician) as limited medical follow up will be provided as part of this program.**

- A referral to a paediatrician is strongly advised if the client does not have one currently.

Exclusion criteria:

The EDP does not provide services in the following instances during this pilot:

a) Unable to eat any solid food/ on Ng tube for eating**

b) Swallowing issues that require involvement of an OT/SLP**

c) Alcohol or substance abuse is the primary presenting problem.

d) The client is acutely suicidal or in crisis.

e) Acute psychiatric disorders account for decrease food intake such as:
   1) Thought disorders (e.g. someone with schizophrenia who has delusions around food).
   2) Major depression or post-partum depression where decrease food intake is due to mood.

** referrals will be forwarded to the BCCH EDP

For more information, please visit : https://www.vch.ca/en/location-service/eating-disorders-program-vancouver

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PILOT -ARFID CLIENT REFERRAL

Please complete the form and fax to (604)675-3894. If you have any questions, please contact (604)675-2531

Date of Referral: _____ For Consult Only: _____

REFERRAL SOURCE: (Primary Care Provider: GP, Pediatrician, Nurse Practitioner) Name:	
Office Phone: Address:	Office Fax:

Client's Surname:	Gender: Preferred Pronouns:
Client's Legal Name: Client's Preferred Name (if different):	DOB: (yyyy/mm/dd) Age:
PHN:	**E-mail:**
Current Address (include postal code):	
Primary Phone # Home/Cell Can Messages be left? Y N Discreet Only	Alternate Phone # Can Messages be left? Y N Discreet Only
Parent/Guardian Name: (Child & Youth)	Phone # **Email:**
May we contact the Client's Parents/Guardian/Contact?	Yes No
Contact Person: (Adult)	Home Phone # Alternate Phone #
Current Height:_____Current Weight: _____ HR lying: _____ HR standing: _____ BP lying: _____ BP standing: _____ ***NOT SELF REPORTED; IN-PERSON HEIGHT & WEIGHT REQUIRED.**	Has there been a recent significant weight loss? Yes No Please explain:

GENERAL EATING DISORDER BEHAVIOURS (See page 4 for ARFID specific symptoms):

Restricting: ☐ Yes ☐ No **Describe**: _____

_____

Purging: ☐ Yes ☐ No **Frequency**:_____

- Vomiting
- Laxatives
- Other (exercise, diuretics, thyroid medications, ipecac, appetite suppressants, insulin manipulation etc.)

_____

Binge Eating (Eating an objectively large amount of food within any 2 hour period, associated with a loss of control)

☐ Yes ☐ No **Frequency**: _____

Body Image Concerns: _____

Other Comments:

MEDICAL HISTORY:

Medical causes of low weight or vomiting ruled out? ☐ Yes ☐ No

Amenorrhea ☐ Yes ☐ No

Last menstrual period: _____

Oral contraceptive: ☐ Yes ☐ No

Pregnant: ☐ Yes ☐ No Week of Pregnancy at Referral:

Diabetes: (insulin dependent) ☐ Yes ☐ No

GI Disorders: _____

Allergies: _____

Other medical conditions:

Current Medications (Please list with dosage):

PSYCHIATRIC HISTORY:
Please describe any psychiatric symptoms of concern or current diagnoses:
(i.e. co-morbid psychiatric dx, suicidal ideation, self-harm, substance abuse)

Is the patient accessing any other psychiatric or psychological support? Other comments?

ARFID SPECIFIC SYMPTOMS & DIAGNOSIS (based on DSM-5):

ARFID Symptoms: Yes ☐ No ☐

- Extreme picky eating
- Lack of enjoyment with eating
- Delayed growth
- Anxiety associated with nausea, choking, allergic reaction or pain with eating.

Suspected ARFID Subtype:

- ☐ Sensory sensitivity to food
- ☐ Lack of Interest in eating
- ☐ Fear of adverse consequences (ie. choking, vomiting, allergic reaction etc)

ARFID Diagnosis: An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:

- Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
- Significant nutritional deficiency.
- Dependence on enteral feeding or oral nutritional supplements.
- Marked interference with psychosocial functioning.

- The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.
- The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.
- The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

Lab Work – A current (within 2 months) copy of the following is required:

1) ECG

2) Full blood biochemistry including all of the below:
   - CBC and Diff
   - Ferritin
   - Random Blood Sugar
   - TSH
   - ALT, AST, Alk Phos, Bilirubin
   - Serum Phosphate, Magnesium, Zinc
   - BUN, Creatinine
   - Na, Cl, K, Bicarb
   - Serum Protein

3) As part of the "Seek and Treat for Optimal Prevention (STOP) of HIV/AIDS" we ask that a routine HIV test be included. For more information on this initiative please contact the Medical Health Officer for Vancouver at 604-675-3900 and/or visit http://hiv.ubccpd.ca/

4) Microscopic Urinalysis to include Specific Gravity.

PLEASE REMEMBER TO COMPLETE THE REFERRAL FORM FULLY AND INCLUDE COPIES OF REQUIRED LAB WORK AND ECG

Incomplete referral forms result in delays.

☐ I understand the VCH Eating Disorder Program is an outpatient eating disorders service and will not assume responsibility for the primary care of this client. Ongoing care is the responsibility of the referring Primary Care Provider.

_____ _____

Primary Care Provider Signature Date

Please fax completed referral to: 604-675-3894

If you have any questions about the services offered or about completing the referral, please call us at 604 675-2531