REFERRAL: North Island Regional Eating Disorders Program

Name:_____ DOB_____
Address: _____ Phone_____
_____ _____
_____
Parents names (for youth):_____

Presenting Problems & Relevant History:

_____
_____
_____
_____

Reason for Referral:

_____
_____
_____

Other Health Care Providers:

_____
_____
_____

Initial Care Plan (i.e. what will be each agency's role and/or client's role)

_____
_____
_____
_____

Referral Source:_____ Date:_____
Agency:_____Phone:_____

Prior to completion of this form, the client will be included in the decision to refer to another agency.

North Island Regional Eating Disorder Program

207, 1040 Shoppers Row
Campbell River, BC V9W 2C6
Tel (250) 850-2620, ext 62962
Fax (250) 850-2464

Comox Valley Hospital – Wellness Centre
101 Lerwick Road
Courtenay, BC V9N 0B9
Tel (250) 331-5900 Ext 65325
Fax (250) 331-5903