BRIDGEPOINT CENTER FOR EATING DISORDERS

PART A - Basic Information (Filled out by applicant)

Program applying for:			
Dates:			
Client name:			
Date of Birth:			
SHSP Number:			
Current Address:			
	Box/Street	**City, Province**	**Postal Code**
Phone Numbers: Home		**Work:**	
Cell:			
Client email address:			
Next of Kin: Name:			
Relationship:		Next of kin will be contacted in emergency situation	
Address:			
	Box/Street	**City, Province**	**Postal Code**
Phone Numbers: Home:		**Work:**	
Cell:			
Counsellor's name:			
Phone:		**Email:**	
Physician's name:			
Phone:		**Email:**	
Date:			
Signature:			

BridgePoint is a Scent Free Facility

BridgePoint Center Inc.
Box 190, Milden, Saskatchewan S0L 2L0
Phone: (306) 935-2240 Fax: (306) 935-2241
Email: bridgepoint@sasktel.net Website: www.bridgepointcenter.ca

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PART A - Getting to know you

1. a) What are your supports?

b) If you are working with a counsellor what issues are you currently working on?

2. Do you have any health issues or concerns?

3. Do you have any allergies?

4. Describe your current experience with food.

5. What other information would you like us to know about you?

Printed Name:	
Signature	
Current Phone Number:	Date:

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PART B – CONFIDENTIAL MEDICAL INFORMATION
Counsellor Referral Information

BridgePoint Center is part of the continuum of services offered in Saskatchewan for the treatment of eating disorders. Our intention is to create a working relationship in service to our mutual client. As such, we request that you provide the following information as part of your referral. You will be contacted to arrange a closure conference call with your client (call of approximately **20 minutes held during the last week of Module) to facilitate the return of your client to an out-patient basis. We encourage all participants to have a scheduled appointment with their home counsellor during the week that they arrive home after Module. All information provided will be held in confidence. Our mutual client will be asked to sign a release of information to facilitate communication**.

Client Name:

How long have you been in therapeutic relationship with this client?

Are you available for ongoing support after your client completes Module?

Please describe the issues your client and you are currently addressing.

Please share any of your client's pertinent history (including any trauma or abuse).

Does your client have an eating disorder diagnosis and/or any concurrent diagnosis?

Do you support your client's choice to attend BridgePoint Center at this time? Do you have any concerns?

Agency Name:

Address:

Cell Number: **Phone Number:** **Fax Number:**

Name and Email Address:

Signature: **Date:**

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

BridgePoint Center is a non-profit provincially approved facility that works in partnership with Heartland Health Region, funded through Saskatchewan Health. We are a continuum of services offered in Saskatchewan for the treatment of eating disorders. Our intention is to create a working relationship in service to our mutual client. As such, we request that you provide the following information as part of your referral. You may be contacted by our Registered Nurse should there be further information required. All information provided will be held in confidence. Our mutual client will be asked to sign a release of information to facilitate communication with both physician and counsellor.

Client Name:_____ **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** *Use back of form if necessary.*
   If yes, list all current prescriptions and PRN(s), (including dosage and frequency)

   _____ _____

   _____ _____

   _____ _____

3. **Please list any PRNs that you have the client on:** _____
4. **Date of last physical examination**: _____

5. **Provide eating disorder diagnosis and list any other concurrent diagnoses:** _____

   _____

   _____

6. **Is there any known substance abuse?**_____

   _____

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

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

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

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

Physicians Name: _____
Please Print

Clinic: _____

Address: _____
Mailing Address City Province Postal Code

Email: _____

Phone Number: _____ **Fax Number:** _____

Signature: _____ **Date:** _____

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