

Referral Form 1

Fax: 416-595-6399 Attention: **Eating Disorders and Addiction Clinic**

RE: Physician Form

Date: _____

To: Eating Disorder and Addiction Clinic

I, Dr. _____ (please print), confirm that
_____ (Name of patient) has been medically cleared
based on relevant laboratory investigations and on a physical exam performed on
_____ (date). This patient can be treated appropriately as an outpatient.

Additional medical conditions or concerns that might impact an outpatient treatment for eating disorders and/or substance use problems:

This patient should be seen for a re-evaluation of his or her medical condition every:

- | | |
|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Week | <input type="checkbox"/> 6 months |
| <input type="checkbox"/> 1 month | <input type="checkbox"/> 12 months |
| <input type="checkbox"/> 3 months | <input type="checkbox"/> Other _____ |

I agree to follow this patient as his or her primary physician whether or not he or she is accepted into the Eating Disorders and Addiction Clinic at CAMH, throughout the assessment process, during treatment, and at any time he or she leaves your program.

Print Name

Signature

Address:
