VCH Eating Disorders Program
3rd Floor 2750 East Hastings
Vancouver, BC V5K 1Z9
Phone: 604-675-2531
Fax: 604-675-3894

Vancouver Coastal Health Eating Disorders Program
BINGE EATING DISORDER 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 group-based treatment program for Binge Eating Disorder clients. The group will run for 10 weeks, 2 hours per session. Clients must be adults over the age of 19 and residents of Vancouver or West/North Vancouver. **Please note this is not a weight loss program.**

The client will have:

A. Recurrent episodes of binge eating
1) Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in in a similar period of time under similar circumstances.
2) A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. Binge eating episodes are associated with three (or more) of the following:
1) Eating much more rapidly than normal.
2) Eating until feeling uncomfortably full.
3) Eating large amounts of food when not feeling physically hungry.
4) Eating alone because of embarrassment.
5) Feeling disgusted with oneself, depressed, or very guilty after overeating.

C. Marked distress regarding binge eating is present.

D. At least once a week for 3 months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior.

Exclusion criteria:

The EDP does not provide services in the following instances:

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

b) The client is acutely suicidal or in crisis.

c) Acute psychiatric disorders account for increased 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 increased food intake is due to mood.

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This referral must be completed in full

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

Date of Referral: _____

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

Client's Surname:	Gender:
Client's First Name:	DOB: (yyyy/mm/dd) Age:
Current Address (include postal code):	
Primary Phone # Home/Cell Can Messages be left? Y N Discreet Only	Email Address
PHN:	Current Height: _____ Current Weight:_____

EATING DISORDER BEHAVIOURS:

Binge Eating
Frequency: _____

Please indicate if patient is engaging in any of the following behaviours:
Restricting: Yes_____ No_____
Over-exercising: Yes_____ No_____
Purging
(self-induced vomiting): Yes_____ No_____
Laxative use: Yes_____ No_____

MEDICAL HISTORY:
Pertinent medical information (allergies, diabetes, GI disorders, and/or 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?

Is this patient medically and psychiatrically stable to participate in a group-based, time-limited program?

☐ I understand the VCH Eating Disorder Program is an outpatient eating disorders service and will not assume responsibility for the primary care or medical monitoring 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