

Dr. Lyndsay Elliott

CLINICAL PSYCHOLOGIST

Physician Referral Form

Patient information	
Name:	
Date of Birth:	
Address:	
Telephone:	
Parent Contact Information:	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Marital status: (Please mark appropriate box)	<input type="checkbox"/> Divorced <input type="checkbox"/> Not disclosed <input type="checkbox"/> Dependent children/Ages <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Single

Physician:
Practice name and address:
Telephone:
Email:
Referral details:
Date of referral: _____ Date patient last seen: _____
Referral priority: <input type="checkbox"/> Routine referral <input type="checkbox"/> Urgent referral
Reason for referral:
Is the patient aware of the referral: <input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Health Issues and Motivation for Treatment:

Current medications:
Known substance abuse history:
Collateral Provider Information or Referrals Requested (dietician, psychiatrist, body composition, etc.):

Eating Disorder Symptoms/Behaviors:
<input type="checkbox"/> Restricted food intake
<input type="checkbox"/> Excessive exercise
<input type="checkbox"/> Binge eating
<input type="checkbox"/> Vomiting/purging
<input type="checkbox"/> Amenorrhea
<input type="checkbox"/> Distorted body image
<input type="checkbox"/> Overweight
<input type="checkbox"/> Diuretic/diet pills/laxative abuse
<input type="checkbox"/> Below normal body weight
<input type="checkbox"/> Suicidal ideation (please describe)
<input type="checkbox"/> Self-harm
Other:

Current Weight/Height:
History of weight gain/loss:
Recommended Weight Range:

Please list Medical Concerns (blood test results, heart rate, pregnancy, etc.):
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Signed:	Date:
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