



REFERRAL: North Island Regional Eating Disorders Program

NAME : _____ D.O.B. _____

ADDRESS: _____ PHONE (home) _____

_____ PHONE (work) _____

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 C/o Comox Valley Nursing Centre

207, 1040 Shoppers Row
Campbell River, BC V9W 3A6
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Fax 250-850-2464

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Courtenay, BC V9N 1R2
Tel 250- 331-8504 Ext. 68419
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