Avoidant/restrictive food intake disorder (ARFID)

CANADIAN PAEDIATRIC SURVEILLANCE PROGRAM
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REPORTING INFORMATION
(To be completed by the CPSP staff)

Report number:	
Month of reporting:	
Province:	
Today's date:	

Please complete the following sections for the case identified above.
Strict confidentiality of information will be assured.

CASE DEFINITION FOR AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER

Report any child or adolescent from age 5 up to the patient's 18th birthday, seen in the previous month, presenting with a newly diagnosed eating or feeding disturbance (e.g., apparent lack of interest in eating or food, avoidance based on the sensory characteristics of food, concern about aversive consequences of eating), as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:

- Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
- Significant nutritional deficiency.
- Dependence on enteral feeding or oral nutritional supplements.
- Marked interference with psychosocial functioning.

Exclusion criteria

The feeding or eating disturbance is:

- a result of lack of available food
- a result of culturally sanctioned practice
- attributed to anorexia nervosa or bulimia nervosa.
- associated with abnormalities in the way in which the young person perceives his/her body weight or shape.
- explained by another medical or mental disorder, so that if treated, the feeding or eating disturbance will go away.

SECTION 1 – DEMOGRAPHIC INFORMATION

Month first seen _____

1.1 Date of birth: _____ /_____ /_____
DD MM YYYY

1.2 Sex: ☐ Male ☐ Female

1.3 Province/Territory of residence: _____

1.4 Ethnicity **(check all that apply):**

☐ Arab	☐ Black	☐ Chinese	☐ Filipino
☐ Japanese	☐ Korean	☐ Latin American	☐ White
☐ First Nations	☐ Inuit	☐ Métis	☐ Unknown
☐ Southeast Asian (e.g., Vietnamese, Cambodian, Malaysian Laotian)	☐ South Asian (e.g., Bangladeshi, Punjabi, Sri Lankan)	☐ West Asian (e.g., Afghan, Assyrian, Iranian)	☐ Other, specify: _____

SECTION 2 – CLINICAL PRESENTATION

2.1 Estimated date of onset of symptoms: _____ /_____ /_____
DD MM YYYY

2.2 Does the patient have an eating or feeding disturbance manifested by persistent failure to meet appropriate nutritional and/or energy needs leading to:

	Yes	No	Unknown
a) Significant weight loss	___	___	___
If yes, specify amount: _____ kg, over what period of time? _____			
b) Failure to achieve expected weight gain	___	___	___
If yes, over what period of time? _____			
c) Faltering growth	___	___	___
If yes, over what period of time? _____			

SECTION 2 – CLINICAL PRESENTATION (cont'd) **Yes** **No** **Unknown**

d) Significant nutritional deficiency ___ ___ ___

e) Dependence on enteral feeding or oral nutritional supplements ___ ___ ___

f) Marked interference with psychosocial functioning ___ ___ ___

If you answered 'No' to ALL questions (a-f) in 2.2, the patient does not meet the criteria for ARFID. Please proceed to section 9 to complete the questionnaire.

2.3 a) Is there evidence of lack of available food? ___ ___ ___

b) Is there an associated culturally sanctioned practice contributing to the weight loss or lack of weight gain? ___ ___ ___

c) Is there an associated general medical condition that is sufficient alone to account for the presentation? ___ ___ ___

d) Does the individual exhibit a disturbance in the way his or her body weight or shape is experienced? ___ ___ ___

If you answered 'Yes' to ANY of the questions in 2.3, the patient does not meet the criteria for ARFID. Please proceed to section 9 to complete the questionnaire.

2.4 Other behaviours/features: **Yes** **No** **Unknown**

- Fasting ___ ___ ___
- Food avoidance ___ ___ ___
- Loss of appetite, little or no desire to eat ___ ___ ___
- Apparent lack of interest in eating or food ___ ___ ___
- Eating, but not eating enough ___ ___ ___
- Eating, but avoiding certain foods ___ ___ ___
- Not initiating eating or seeking out food as expected ___ ___ ___
- Preoccupation with food/food intake ___ ___ ___
- Denial of severity of illness ___ ___ ___
- Self-induced vomiting ___ ___ ___
- Somatic complaints (e.g., headache, abdominal pain) ___ ___ ___
  If yes, describe: _____
- Exercising (e.g., running, swimming) ___ ___ ___
  If yes, specify: frequency: _____ hours/day or _____ hours/week
  Forms of exercise used: _____
- Compensatory weight loss methods ___ ___ ___
  If yes, check all that apply: ☐ laxatives ☐ diuretics ☐ diet pills abuse
  ☐ complementary and alternative medications use
  ☐ others, describe: _____
- History of symptoms preceding the onset of the disordered eating ___ ___ ___
  If yes, check all that apply: ☐ choking ☐ gagging ☐ vomiting
- History of documented food allergy ___ ___ ___
  If yes, specify what food: _____
- Swallowing difficulties ___ ___ ___
- Refusal to eat due to a dislike of certain sensory characteristics of foods ___ ___ ___
  If yes, check all that apply: ☐ taste ☐ texture ☐ colour ☐ smell
- Secondary gain (i.e., advantage that occurs secondary to stated or real illness) ___ ___ ___
  If yes, describe: _____

SECTION 3 – PHYSICAL FEATURES

		Yes	No	Unknown
3.1	Current weight: _____ kg			
3.2	Current height: _____ cm			
3.3	Based on THIS assessment, what do you think the patient's weight SHOULD be (i.e., the weight for optimal health)? _____ kg			
3.4	Maximum weight ever recorded: _____ kg date recorded: ____ /_____ /_____ DD MM YYYY			
3.5	Lowest weight record since start of symptoms: _____ kg date recorded: ____ /_____ /_____ DD MM YYYY			
3.6	If height has changed in last six months, specify the amount increased: _____ cm			
3.7	Heart rate at presentation: _____ beats/minutes			
3.8	At presentation – patient's condition **(check all that apply):** ☐ Arrhythmias ☐ Dehydration ☐ Muscle wasting ☐ Syncope ☐ Dizziness ☐ Constipation ☐ Gastro-esophageal reflux ☐ Hypotension (systolic BP <80 if under 10 years, or <90 if over 10 years) ☐ Hypothermia (oral temperature <35.5ºC)			
3.9	**If female,** has patient reached menarche? ☐ Not applicable	___	___	___
	If yes, is she menstruating regularly?	___	___	___
	If menstruating, is she on hormonal contraceptives?	___	___	___
	Date of last normal menstrual period: _____ /_____ /_____ DD MM YYYY			
3.10	Indicate pubertal status based on Sexual Maturity Rating (SMR), also known as Tanner staging: Stage (1–5) _____ Breast development _____ Male external genitalia _____ Pubic hair			
3.11	Electrolyte abnormalities	___	___	___
	If yes, specify: _____			

SECTION 4 – SOCIAL HISTORY

		Yes	No	Unknown
4.1	Have there been any major changes in social relationships now or in the past?	___	___	___
	If yes, specify **(check all that apply):** ☐ peers ☐ family ☐ school move ☐ significant peer group switch ☐ other, describe: _____ _____			
4.2	Have there been any recent losses or significant stressors for the child or in the family?	___	___	___
	If yes, specify **(check all that apply):** ☐ death in family ☐ financial stress ☐ separation ☐ divorce ☐ death of a pet ☐ other, describe: _____			
4.3	Past or current history of **(check all that apply):**			
	• Abuse	___	___	___
	If yes, specify: ☐ sexual ☐ physical ☐ emotional			
	• Victim of bullying	___	___	___
	If yes, was bullying weight-based?	___	___	___
	• Self-harm behaviour	___	___	___
	• Suicidal behaviour	___	___	___

SECTION 5 – MEDICAL ILLNESS

		Yes	No	Unknown
5.1	Is there a current comorbid medical illness?	___	___	___
	If yes, specify:			
	• A well established medical condition that contributes to the disordered eating	___	___	___
	• An unexplained somatic symptom that contributes to the disordered eating	___	___	___

SECTION 6 – PSYCHIATRIC ILLNESS

		Yes (current history)	No (current history)	Unknown (current history)	Yes (past history)	No (past history)	Unknown (past history)
6.1	**Patient's history**						
	• Depression	___	___	___	___	___	___
	• Anxiety disorder	___	___	___	___	___	___
	• Obsessive-compulsive disorder	___	___	___	___	___	___
	• Attention deficit disorders	___	___	___	___	___	___
	• Alcohol/substance use/abuse	___	___	___	___	___	___
	• Autism spectrum disorder	___	___	___			
	• Intellectual or cognitive impairment	___	___	___			
	• Anorexia nervosa				___	___	___
	• Bulimia nervosa				___	___	___
	• Others, specify for current history: _____						
	• Others, specify for past history:_____						

		Yes	No	Unknown
6.2	**Family history**			
	• Depression	___	___	___
	• Anxiety disorder	___	___	___
	• Obsessive-compulsive disorder	___	___	___
	• Anorexia nervosa	___	___	___
	• Bulimia nervosa	___	___	___
	• Attention deficit disorders	___	___	___
	• Autism spectrum disorder	___	___	___
	• Alcohol/substance use/abuse	___	___	___
	• Attempted suicide	___	___	___
	• Completed suicide	___	___	___
	• Others, specify: _____			

SECTION 7 – MANAGEMENT OF THE FEEDING OR EATING DISTURBANCE

7.1 The management included **(check all that apply):**

☐ Regular outpatient medical monitoring ☐ Family therapy ☐ Psychoeducation

☐ Nutritional counseling by dietitian ☐ Individual therapy

- Further diagnostic psychiatric assessment/evaluation? ☐ Yes ☐ No
- Further subspecialty medical evaluation? ☐ Yes ☐ No

If yes, specify paediatric/medical subspecialty: _____

_____

SECTION 7 – MANAGEMENT OF THE FEEDING OR EATING DISTURBANCE (cont'd) **Yes** **No** **Unknown**

7.2 Is this patient taking current medications? ___ ___ ___

If yes, specify medications and dosage: _____

_____

_____

7.3 Is there a possibility that this child may need an admission in the near future? ___ ___ ___

7.4 **Medical hospitalization for the present disorder?** ___ ___ ___

If no, go to question 7.5

If yes, specify reason: _____

- Paediatric/medical subspecialty consultations ___ ___ ___

  If yes, specify subspecialty: _____

  Reason: _____

- Was a supplementary nutritional intervention required? ___ ___ ___

  If yes, check all that apply:

  ☐ oral nutritional supplements ☐ nasogastric tube feeding

  ☐ gastrostomy tube feeding ☐ total parenteral nutrition

  ☐ other, specify _____

- Length of stay: ____ days ____ weeks ____ months

7.5 **Inpatient PSYCHIATRIC hospitalization for the present disorder?** ___ ___ ___

If no, go to question 7.6

If yes, specify reason: _____

- Length of stay: ____ days ____ weeks ____ months

7.6 **Day treatment/partial hospitalization for the present disorder?** ___ ___ ___

If no, go to question 7.7

If yes, specify reason: _____

- Length of stay: ____ days ____ weeks ____ months

7.7 **Previous medical admissions?** ___ ___ ___

If no, go to question 7.8

If yes, specify how many: _____ Reasons: _____

7.8 **Previous psychiatric admissions?** ___ ___ ___

If no, go to question 8.1

If yes, specify how many: _____ Reasons: _____

SECTION 8 – FOLLOW-UP

8.1 Specify the follow-up plan for this patient **(check all that apply):**

☐ I will follow myself

☐ I will refer to medical/psychiatric specialist or psychologist

☐ I will send back to primary care physician

☐ This patient is being referred to/followed by an eating disorder program

☐ **I agree to be contacted by the CPSP for further information.**

☐ **I do not wish to be contacted by the CPSP for further information.**

SECTION 9 – REPORTING PHYSICIAN

I am a: ☐ **paediatrician**

☐ **paediatric subspecialist; indicate subspecialty:**_____

First name_____ Surname_____

Address_____

City_____ Province_____ Postal code_____

Telephone number_____ Fax number_____

E-mail_____ Date completed_____

Thank you for completing this form.

(ARFID 2016/01)