GPH Eating Disorder Service

Medical Practitioner Referral Form – Adolescent (12-17 years)

Specialist Eating Disorder Service

Please complete and return via fax to: **4226 6489**. For enquiries contact: **1800 228 987**

REFERRAL INFORMATION

☐ I have enclosed an Eating Disorder Treatment and Management Plan

☐ I have enclosed a Mental Health Treatment Plan

☐ I have enclosed a Chronic Disease Management Plan

PATIENT'S DETAILS

Name: _____ ☐Male ☐Female DOB:_____

Address:_____

Preferred Language (& dialect): _____ Interpreter Required: ☐Yes ☐No

Phone – Home:_____ Mobile:_____

Medicare No:_____ Ref No: ____ Expiry: ____ / _____

Health Fund ☐Yes ☐No Name of health fund: _____ Membership No_____

Parent/Guardian name: _____

Phone – Home: _____ Mobile: _____

The patient has consented to this referral ☐Yes ☐No Please note, we are unable to make contact with them if No

REFERRER INFORMATION

Name: _____

Name of Practice: _____

Address: _____

Phone: _____ Fax: _____

I am a: ☐GP / ☐Other Specialist (Specify): _____

GP'S DETAILS (if not the referrer)

Name:_____

Name of Practice: _____

Address: _____

Phone: _____ Fax: _____

OTHER SERVICES/CLINICIANS INVOLVED IN PATIENT CARE

Name	Organisation	Profession	Contact Number

MEDICAL HISTORY

MEDICATIONS

Name	Indications	Dose	Frequency	Prescribed by	Duration

ASSESSMENT

EATING DISORDER ASSESSMENT

Diagnosed Eating Disorder:

☐ Yes - Diagnosis: _____ Severity (DSM V): _____ Duration: _____

☐ No - Disordered Eating Behaviours:

☐ Restricting food intake ☐ Binge eating ☐ Excessive exercise ☐ Vomiting ☐ Laxative misuse

☐ Other (specify) _____

GPH Eating Disorder Service

MEDICAL ASSESSMENT			
Test	Result	Tick all that apply **Can be treated in Community Setting**	Tick all that apply **Hospital Admission Indicators**
Body Weight			
BMI:	_____	☐ ≥ 16kg/m^2	☐ ≤ 14kg/m^2
Recent weight loss:	_____	☐ < 1kg per week	☐ ≥ 1kg per week for 6 or more weeks
Vital Signs			
Temperature:	_____	☐ Within Normal Limits	☐ < 35.5 °C
Blood Pressure:	_____	☐ Within Normal Limits	☐ < 80/40 mmHg
Postural Blood Pressure	_____	☐ Within Normal Limits	☐ > 30mmHg drop with standing
Heart rate:	_____	☐ Within Normal Limits	☐ < 50bpm
Postural Tachycardia	_____	☐ Within Normal Limits	☐ > 20 bpm increase on standing
Dehydration	_____	☐ Within Normal Limits	☐ specific gravity ≥ 1020 and refusal to eat or drink
Laboratory Assessment			
Glucose:	_____	☐ Within Normal Limits	☐ < 3.0 mg/dL
Potassium:	_____	☐ Within Normal Limits	☐ ≤ 3.0mmol/L
Other electrolytes	_____	☐ Within Normal Limits	☐ Hypokalaemia ☐ Hyponatraemia ☐ Hypophosphataemia ☐ Hypomagnesaemia

Investigations		
ECG _____	☐ Normal sinus rhythm	☐ Any arrhythmia including a prolonged QTc interval (> 450milliseconds)
Based on psycho-social findings:		
Suicidality with active intent and plan	☐ No	☐ Yes
Other Considerations		
Pregnant	☐ No	☐ Yes
Diabetic	☐ No	☐ Yes
Overall Assessment	☐ **Appropriate for treatment at GPH Eating Disorder Service**	☐ **Inappropriate for treatment at GPH Eating Disorder Service Requires Immediate Hospitalisation**

MEDICAL MONITORING

Having completed the above medical checks, I have assessed the patient as appropriate for treatment at GPH Eating Disorder Service, requiring the following:

☐ weekly medical monitoring (for diagnosed eating disorders)

☐ medical monitoring as clinically indicated (for disordered eating behaviours)

MEDICAL PRACTITIONER ACKNOWLEDGEMENT

☐ As the referring medical practitioner/GP I understand that this referral will not be actioned unless GPH Eating Disorder Service receives the required information.

☐ As the referring medical practitioner/GP I am aware that the patient requires ongoing assessment of medical and psychiatric stability including the need for hospital admissions, and that GPH Eating Disorder Service does not provide this -

☐ I will provide ongoing medical and psychiatric assessment and management of this patient during their treatment

OR ☐ I have made arrangements for another medical practitioner to provide this care (specify):

Dr: _____ Phone: _____

Signature: _____ Date _____

Provider Number: _____