GPH Eating Disorder Service

Medical Practitioner Referral Form – Adults (≥18 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_____

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) _____

_____

_____

_____

_____

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MEDICAL ASSESSMENT				
		Tick all that apply		
Test	**Result**	**Can be treated in Community Setting**	**Psychiatric or Medical Admission indicated - high clinical/psychosocial risk**	**Acute Medical Admission Required – extreme clinical risk**
Based on Clinical Findings				
BMI:	_____	☐ ≥ 16kg/m^2	☐ < 16kg/m^2	☐ < 14kg/m^2
Recent Weight Loss:	_____	☐ <1kg per week	☐ 1kg per week over several weeks	☐ >1kg per week over several weeks
Temperature:	_____	☐ 35.5 to 37.5°C	☐ < 35.5 °C	☐ < 35 °C
Systolic Blood Pressure:	_____	☐ 90 to 129mmHg	☐ < 90mmHg	☐ < 80mmHg
Postural Blood Pressure Drop	_____	☐ ≤ 10mmHg drop with standing	☐ > 10mmHg drop with standing	☐ > 20mmHg drop with standing
Heart Rate:	_____	☐ 40-110bpm		☐ < 40bpm ☐ > 110bpm
Postural Tachycardia	_____	☐ ≤ 10bpm increase on standing		☐ > 10bpm increase on standing
Based on Investigations Findings:				
Blood Sugar:	_____	☐ Within normal limits	☐ < 3.5 mmol/L	☐ < 2.5 mmol/L
Sodium:	_____	☐ Within normal limits	☐ < 130 mmol/L	☐ < 125 mmol/l
Potassium:	_____	☐ Within normal limits	☐ < 3.5 mmol/L	☐ < 3.0 mmol/L

Magnesium: _____	☐ 0.7 to 1.1mmol/L		☐ < 0.7 mmol/L
Phosphate: _____	☐ 0.8 to 1.5mmol/L		☐ < 0.8mmol/L
Albumin: _____	☐ 35 to 50g/L	☐ < 35g/L	☐ < 30g/L
Liver Enzymes: _____	☐ Within normal limits	☐ mildly elevated	☐ AST or ALT > 500
Neutrophils: _____	☐ Within normal limits	☐ < 2.0 x 10^9/L	☐ < 1.0 x 10^9/L
ECG - Cardiac Arrhythmia _____	☐ No		☐ Yes ☐ QTc prolongation ☐ Non-specific ST ☐ T-wave changes including inversion or biphasic waves
Based on psycho-social findings:			
Responding to Outpatient Treatment	☐ Yes	☐ No	
Suicidality with Active Intent and Plan	☐ No	☐ Yes	
Overall assessment	☐ **Appropriate for treatment at GPH Eating Disorder Service**	☐ **Inappropriate for treatment at GPH Eating Disorder Service Requires emergency assessment for hospital admission**	☐ **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)

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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: _____