GPH Eating Disorder Service

Referral Form – Other Organisation, Support Service or Allied Health Professional

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

CLIENT'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_____
If under 16, are the client's parents/carers aware of this referral? ☐Yes ☐No
Is there a family member/worker who the client would like us to speak to? ☐Yes ☐No
Name: _____ Ph/Mob: _____
Relationship to client: _____

REFERRER INFORMATION

Name: _____
Phone:_____ Email:_____
Organisation: _____ Role: _____
The patient has consented to this referral ☐Yes ☐No Please note, we are unable to make contact with them if No

GP'S DETAILS

Name:_____
Name of Practice:_____
Address: _____
Phone:_____ Fax:_____

OTHER SERVICES/SUPPORTS/CLINICIANS INVOLVED IN CLIENT'S CARE

Name	Organisation	Profession	Contact Number

MEDICAL CONDITIONS/DIAGNOSES

_____
_____
_____
_____

MEDICATIONS					
Name	Indications	Dose	Frequency	Prescribed by	Duration

DISORDERED EATING BEHAVIOURS (tick all that apply)

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

☐ Other (specify) _____

_____

WEIGHT HISTORY

Weight: _____kg Height: _____m

☐ Weight Loss How much? _____ Time frame: _____

☐ Weight gain How much? _____ Time frame: _____

Highest weight: _____ kg Date_____

Lowest weight: _____ kg Date_____

CONSENT TO REFERRAL

- The client is aware that this referral is being made. The client understands that they can withdraw from this referral or the referred service at any time.
- The client consents to GPH Eating Disorder Service obtaining relevant information from agencies, doctors and other allied health professionals, specifically relevant to the client's care, whilst being a client of the GPH Eating Disorder Service

Signed: _____ Print Name: _____ Date: _____