# GPH Eating Disorder Service

## Referral Form

**For office use only:** ☐ Phone referral. Filled in by: _____ Date: _____

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

**Information Required**

**General Practitioners or Specialist Medical Practitioners, please complete sections 1, 2 and 3**
**All other referrers (including allied health professionals) please complete section 1 only.**

### SECTION 1

SUITABILITY CRITERIA

☐ 12 years or older
☐ have an eating disorder or an unhealthy relationship with food
☐ be willing to have ongoing engagement with a GP as part of care

CLIENT'S DETAILS

Name: _____ DOB:_____

Gender: ☐Male ☐Female ☐Intersex ☐ Indeterminate ☐ Transgender ☐ Genderqueer/Gender nonconforming

Preferred Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐They/Them/Theirs

Address:_____

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

Phone – Home:_____ Mobile:_____

Medicare No:_____ Reference No: _____

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

If a minor: Parent/Guardian name: _____

Phone – Home: _____ Mobile: _____

REFERRER INFORMATION

Name: _____

Phone: _____ Email: _____

Relationship to client: _____

CONSENT TO REFERRAL

☐ The client is aware that this referral is being made.
☐ The client understands that they can withdraw from this referral or referred service at any time.
☐ The client consents to being contacted by GPH Eating Disorder Service in relation to this referral
☐ 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: _____ Date: _____

Print Name: _____

## SECTION 2

**To be completed by General Practitioners or Specialist Medical Practitioners Only**

GENERAL OR SPECIALIST MEDICAL PRACTITIONER DETAILS

Name:_____

Name of Practice: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

PRIMARY CONCERNS/PRESENTING PROBLEM

RELEVANT MEDICAL HISTORY

MEDICARE TREATMENT PLAN

☐ 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

☐ I have enclosed an Allied Health Services for People of Aboriginal and Torres Strait Islander Descent management plan

# GPH Eating Disorder Service

## SECTION 3

**To be completed by General Practitioners or Specialist Medical Practitioners Only**

MEDICAL ASSESSMENT

| Test | Result | Tick all that apply: Can be treated in Community Setting | Psychiatric or Medical Admission indicated - high clinical or 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 | Adult:<br>☐ 1kg per week over several weeks | Adolescent:<br>☐ ≥1kg per week for 6 or more weeks<br>Adult:<br>☐ >1kg per week over several weeks |
| Temperature: | _____ | ☐ 35.5 to 37.5°C | Adult:<br>☐ < 35.5 °C | Adolescent:<br>☐ <35.5 °C<br>Adult:<br>☐ <35 °C |
| Systolic Blood Pressure: | _____ | ☐ 90 to 129mmHg | ☐ < 90mmHg | ☐ < 80mmHg |
| Postural Blood Pressure Drop | _____ | ☐ ≤ 10mmHg drop with standing | ☐ > 10mmHg drop with standing | Adolescent:<br>☐ >30mmHg drop with standing<br>Adult:<br>☐ >20mmHg drop with standing |
| Heart Rate: | _____ | Adolescent:<br>☐ 50-110bpm<br>Adult:<br>☐ 40-110bpm | | Adolescent:<br>☐ <50bpm<br>Adult:<br>☐ < 40bpm<br>☐ > 110bpm |
| Postural Tachycardia | _____ | Adolescent:<br>☐ ≤20bpm increase on standing<br>Adult:<br>☐ ≤10bpm increase on standing | | Adolescent:<br>☐ >20bpm increase on standing<br>Adult:<br>☐ >10bpm increase on standing |
| **Based on Investigations Findings:** | | | | |
| Blood Sugar: | _____ | ☐ Within normal limits | Adult:<br>☐ < 3.5 mmol/L | Adolescent:<br>☐ <3.0mg/dL<br>Adult:<br>☐ < 2.5 mmol/L |
| Sodium | _____ | ☐ Within normal limits | Adult:<br>☐ < 130 mmol/L | Adolescent:<br>☐ Abnormal<br>Adult:<br>☐ < 125 mmol/l |

| | | | |
|---|---|---|---|
| Potassium: _____ | ☐ Within normal limits | Adult:<br>☐ < 3.5 mmol/L | Adolescent:<br>☐ Abnormal<br>Adult:<br>☐ < 3.0 mmol/L |
| Magnesium: _____ | ☐ Within normal limits | Adult:<br>☐ 0.7-1.0 mmol/L | Adolescent:<br>☐ Abnormal<br>Adult:<br>☐ < 0.7 mmol/L |
| Phosphate: _____ | ☐ Within normal limits | Adult:<br>☐ 0.8mmol/L | Adolescent:<br>☐ Abnormal<br>Adult:<br>☐ < 0.8mmol/L |
| Albumin: _____ | ☐ Within normal limits | ☐ < 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<br>☐ QTc prolongation<br>☐ Non-specific ST<br>☐ T-wave changes<br>including inversion or biphasic waves |
| Based on psycho-social findings: | | | |
| Responding to community-based 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)

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: _____