NWMH516

The Royal Melbourne Hospital

Eating Disorder Program Referral

ATTACH LABEL OR RECORD PATIENT DETAILS					
LOCAL UR		MH UR			
NAME					
ADDRESS					
PHONE		DOB		SEX	

Reason for referral:

☐ Inpatient admission

☐ Outpatient group sessions (STEPS Program)

☐ Secondary consultation

☐ Outpatient dietetics support (patient must be linked with local area mental health service)

I have assessed the patient and acknowledge that the patient does not need immediate admission as per the RANZCP Clinical Practice Guidelines for Eating Disorder Management

☐ Yes ☐ No

I will continue to medically monitor this patient whilst awaiting outcome of the referral

☐ Yes ☐ No

I acknowledge that an incomplete referral will delay consideration of my referral until all information has been provided

☐ Yes ☐ No

Is the patient aware of this referral and do they consent to this referral?

☐ Yes ☐ No

Patient Information:

Full Name			
Address			
Date of Birth		Gender	
Email		Preferred Pronouns	
Phone Number		Preferred Language	
Aboriginal and/or Torres Strait Islander		Interpreter Required	
Allergies		Cultural Considerations	
Private Health Insurance Details			
Next of Kin (if any) and relationship to patient			

Legal Status (Is the patient subject to a treatment order under the Mental Health Act 2014?)

☐ Yes ☐ No If Yes, Please Specify:

Current Situation:

Referrer Information:

Name			
Address			
Position (GP, Private Psychiatrist)		Service	
Phone		Fax	
Email		Date of referral	

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GP Details (if not referrer):

Full Name			
Address			
Practice		Phone	

Treatment Team (i.e. Psychologist, Dietitian, Case Manager, etc)

Full Name	Profession	Phone	Fax

Eating disorder symptoms:

Behaviours	Y/N	Details: i.e. frequency/duration, name of medications, quantities
Oral restriction (food and/or fluid)		
Purging/vomiting		
Laxatives/diuretics/diet pills		
Exercise		
Preoccupation with weight and shape		

Psychosocial Information

Accommodation Details (E.g., homeless, renter)		Is the patient receiving Centrelink payments?	
Does the patient have dependents? (If yes, please specify age)		Employment Status	

Eating Disorder History

Diagnosis	
Previous admissions; Include medical and Eating Disorder Unit admissions	
Previous engagement with outpatient eating disorder programs	
Family history of eating disorder	

Psychiatric History and Risk

Other Psychiatric Diagnoses (e.g. Depression, OCD or Personality Disorder)

History of psychiatric admissions or case management

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History of suicide attempts or self-harming behaviours

Substance abuse

Family history of suicide, mental illness and/or substance use

Forensic history

History of violence or assault towards others

Current mental state

Medical Assessment:

Date of physical examination:

Weight (kg)		Height (cm)	
BMI (kg/m2)		Weight loss (kg), time period	
Premorbid weight (kg)		Desired weight (kg)	
Blood pressure (sitting)		Heart rate (sitting)	
Blood pressure (standing)		Heart rate (standing)	
Temperature		Blood Glucose Level	

Physical signs and symptoms:

e.g (cognitive slowing, fatigue, palpitations, dizziness, syncope, amenorrhoea)

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Please include copies of the following investigations:

- Pathology results (UEC, FBE, CMP, LFT, TFT, blood glucose, B12, folate, vitamin D, iron studies)
- ECG if available
- DEXA scan if available

If currently admitted to hospital please attach the following information to your referral:

- Food and fluid balance chart
- Current meal plan, dietitian assessment
- Bowel chart
- Medication chart
- Current medical impression and treatment plan
- Mental Health Act paperwork

Medication and Supplements List:

Medication	Dose	Frequency	Prescriber

Additional Information:

Clinician Name (print):	Signature:	Designation:	Date:

Date
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