Wellness and Recovery Centre, Eating Disorder Program
Medical Practitioner Referral Form

Please complete and fax to Wellness and Recovery Centre.

Phone: 9594 1770 ***Fax no: 9594 4465***

Patient Information

Name: M or F DOB:

Address: Preferred Language (& dialect):

Telephone – Hm: Mb: Interpreter Required: Yes/ No

Has the client consented to referral? Yes / No ***(if no please get client consent before proceeding)***

Referrer Information (if not GP)

Referrer Name: Position: Service:

Contact – Ph: Fax: Email:

Is the GP aware, and consenting to referral? Yes / No ***(requires GP endorsement before proceeding)***

General Practitioner Information

GP Name: Name of Practice:

Address:

Contact – Ph: Fax: Email:

Reason for referral:

- ☐ Consideration for Inpatient admission (ages 18 - 64)
- ☐ Consideration for Outpatient treatment (ages 18 - 64)
- ☐ Consideration for Butterfly Day Program (ages 12 - 24)
- ☐ Assessment and diagnostic clarification
- ☐ Secondary consultation re patient management
- ☐ Other _____

Current Supports/Other Clinicians Involved in Patient Care: *eg. psychological, dietetic, other*

Name	Organisation	Profession	Contact Number

Presenting Issue: *include hx of eating disorder: onset, course, duration and previous treatment*

Specifics of Weight Control Behaviour: *include frequency and duration if known*

Restricting Food	Yes	No	details:
Binge Behaviour	Yes	No	details:
Laxative Use	Yes	No	details:
Vomiting	Yes	No	details:
Diet Pills	Yes	No	details:
Exercise	Yes	No	details:
Other	Yes	No	details:

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Substance Use:

- ☐ Current drug abuse details:
- ☐ Current drug dependence details:
- ☐ Past drug use details:

Psychiatric History

- ☐ Depression
- ☐ Anxiety
- ☐ Psychosis
- ☐ Bipolar
- ☐ Personality Disorder
- ☐ Other:_____

- ☐ Self harm attempt(s) details:
- ☐ Suicide attempt(s) details:
- ☐ Inpatient admission(s) details:

Medical History/General Health:

Other Physical Symptoms:

GIT	Hair & Skin	CVS	CNS
☐ Constipation ☐ Bloating ☐ Abdominal pain ☐ Retrosternal pain	☐ Hair loss ☐ Lanugo hair ☐ Poor cold tolerance ☐ Dry hair/skin ☐ Cool periphery ☐ Easy bruising ☐ Delayed wound healing	☐ Dizziness ☐ Fainting ☐ Paresthesia ☐ Shortness of breath ☐ General weakness ☐ Peripheral oedema	☐ Altered concentration ☐ Mood changes ☐ Increasingly withdrawn

Other:

☐ Amenorrhea Yes / No / Unknown (eg on contraceptive)

☐

Allergies/ Dietary Requirements (Intolerances):

Medications: *(please add additional sheet if needed)*

Name	Dose	Frequency	Prescribed by	Duration

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Physical Examination on / /

	Lying	Standing
Heart Rate	bpm	bpm
Blood Pressure	mmHg	mmHg

Temperature: _____ °c

Weight: _____kg, Height: _____cm, BMI: _____

Hx of weight changes:

_____

_____

Investigations: *Please attach pathology results when faxing back this form*

Please conduct the following investigations: *(please indicate with ✓or X)*

Required Analysis:

- ☐ FBE
- ☐ U&E, Uric Acid, Bicarb
- ☐ Ca, Mg, PO4, Zn
- ☐ Fe studies
- ☐ B12/Folate/Vit D
- ☐ TFT
- ☐ Finger prick/Random Glucose
- ☐ LFT
- ☐ Lipids
- ☐ ECG

Further Investigations: *(conduct if indicated*

- ☐ FSH & LH Oestradiol
- ☐ Ovarian USG
- ☐ X-Ray &/or DEXA Scan
- ☐ CT/MRI brain/EEG
- ☐ Other_____

Please see "Brief guide to Medical Monitoring of Eating Disordered Clients" for further information re indications

Dexa scan performed? ☐ Yes ☐ No If yes, please provide date of investigation: _____

Mental State Examination:

Any additional comments:

GP/Referrer Signature: **Date:** **Best time to be contacted re referral:**

*Please note: If there are immediate concerns/risk, please contact psychiatric triage on **1300 369 012** or have client present to the Emergency Department of their local hospital.*

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