Advanced Psychology Services

Treatment of Eating Disorders

REFERRAL FORM

To be completed by a Medical Doctor or other Health Professional. Please consider if patient is eligible for a Mental Health Care Plan or Eating Disorders Treatment Plan through Medicare.

Client information

Name: _____
Last First Middle

Address: _____

Age: _____ Date of Birth: _____ Gender: F ❑ M ❑ Other ❑

Aboriginal/Torres Strait Islander Y ❑ N ❑

Telephone Number: _____ Email: _____

If under the age of 18 years

Parent/Guardian name:_____

Telephone Number: _____ Email: _____

School: _____ Year Level

Is the person a previous patient of Advanced Psychology Services? No ❑ Yes ❑ When _____

Referrer information

Name _____ Position_____ _____

Contact number _____ Fax _____ _____

I confirm the patient/guardian has consented to this referral ❑

Presenting eating disorder symptoms

Is this client a current inpatient? Yes ❑ No ❑ If yes, where:_____

Behaviours		Comments (e.g., extent, frequency)
Restricting food intake	Yes ❑ No ❑	
Binge eating	Yes ❑ No ❑	
Vomiting	Yes ❑ No ❑	
Laxatives	Yes ❑ No ❑	
Exercising excessively	Yes ❑ No ❑	
Amenorrhea	Yes ❑ No ❑	
Other:		

Current weight _____kg Height_____ m BMI_____

Weight history

Highest weight _____kg When_____ Lowest weight _____kg When_____

Weight changes in last 6 months _____ _____

This patient is suitable for outpatient treatment (e.g., medically stable) Yes ❑ No ❑ Unknown ❑

Eating disorder treatment history

		When	Currently involved?	Any comments on treatment response
Hospital program	Yes ❑ No ❑			
Medical outpatient (e.g., paediatrician)	Yes ❑ No ❑			
Psychologist	Yes ❑ No ❑			
Psychiatrist	Yes ❑ No ❑			
Dietician / Other	Yes ❑ No ❑			

Other history

Please tick if the person has ever had contact with the following:

❑ Statewide Eating Disorder Service (SEDS)

❑ Statewide Paediatric Eating Disorders Services (SPEDS)

❑ Women's & Children's Hospital (mental health and/or eating disorders services)

❑ Department for Child Protection (DCP)

❑ Child and Adolescent Mental Health Service (CAMHS)

Other psychiatric or substance use issues (current or past, e.g., depression, anxiety)

_____Current? Yes ❑ No ❑ Treatment Hx:_____

_____Current? Yes ❑ No ❑ Treatment Hx:_____

_____Current? Yes ❑ No ❑ Treatment Hx:_____

Self-harm and risk issues

Has the person self-harmed in the last 3 months?

Suicide attempt: Yes ❑ No ❑ Non-suicidal self-harm: Yes ❑ No ❑

Details _____

If the patient has made a suicide attempt within the last 3 months, we would recommend seeking alternative treatment options and re-referring your patient following a period of at least 3 months with no suicide attempt and reduced level of risk.

Prior to the last 3 months, does the patient have a history of suicide attempts or other self-harm?

Suicide attempt: Yes ❑ No ❑ Non-suicidal self-harm: Yes ❑ No ❑

When_____

What is your assessment of the patient's current level of self-harm risk?

_____

Any further information you wish to provide

_____

_____

❑ GP or other health professional referral attached for psychiatrist Dr Michael Batterham

Please specify

I will be providing ongoing medical/psychiatric care ❑

Or _____ will provide ongoing medical/ psychiatric care ❑

I understand that for referrals with significant comorbidity or self-harm/risk issues, ongoing psychiatric care will need to continue elsewhere so that our clinic is able to focus primarily on the treatment of the eating disorder.

Signed (referrer):_____ Dated: _____

Please return referral form via email info@advancedpsychology.com.au or fax (08) 8227 0937.

Advanced Psychology Services
164-168 Angas Street, Adelaide, SA 5000 · P: (08) 7324 3055 · F: (08) 8227 0937
E: info@advancedpsychology.com.au · www.advancedpsychology.com.au