WA Eating Disorders Outreach & Consultation Service

REFERRAL FORM

CONSUMER DETAILS

UMRN Click here to enter text.

Surname Click here to enter text.

Given Names Click here to enter text.

D.O.B. Click here to enter text. | **Sex** Click here to enter text.

Address Click here to enter text.

CURRENT LOCATION

Inpatient ☐ Outpatient ☐

Community ☐

IDENTIFY (1)

REFERRING CLINICIAN'S DETAILS

Date Click here to enter a date. **Time** Click here to enter text.

Name Click here to enter text. **Designation** Click here to enter text.

Organisation Click here to enter text.

Address Click here to enter text.

Telephone / Mobile Click here to enter text. **Fax** Click here to enter text.

Email Click here to enter text.

Public ☐ **Private** ☐ **NGO** ☐ **GP** ☐

WAEDOCS staff member contacted (if applicable)

CONSUMER'S CONTACT PERSON DETAILS

Name Click here to enter text. | **Relationship** Click here to enter text.

Contact number Click here to enter text.

SITUATION (2)

REFERRAL DETAILS

Please indicate which is appropriate

Referral for specific patient input ☐
(Complete box 1 – 5 and email to WAEDOCS)

General Eating Disorder Information only ☐
(Complete box 1 – 2 and email to WAEDOCS)

Reason for referral / advice Click here to enter text.

CURRENT SYMPTOMS AND NUTRITION

Symptoms Click here to enter text.

Current feeding regime (choose one)

Oral diet only ☐ **NGT feeding** ☐ **Combined / Transitional** ☐

OBSERVATIONS (3)

CURRENT OBSERVATIONS

Weight (kg) Click here to enter text. | **Height (m)** Click here to enter text. | **BMI (kg/m^2)** Click here to enter text.

Weight History Click here to enter text. | **Lowest BMI during admission** Click here to enter text.

Postural Tachycardia Click here to enter text.

QTc Segment Measurement on ECG Click here to enter text.

Blood Glucose Level (trend) Click here to enter text.

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BACKGROUND (4)

CURRENT HISTORY

History of Eating Disorder

No Diagnosis ☐ **Anorexia Nervosa** ☐ **Bulimia Nervosa** ☐

Binge Eating Disorder ☐ **Other Specified Feeding and Eating Disorder** ☐

Duration of Illness Click here to enter text.

Is there a history of Treatment under Mental Health Act (MHA)?	**Yes** ☐	**No** ☐
Is the patient currently under MHA?	**Yes** ☐	**No** ☐
Is the patient known to Child & Adolescent Mental Health Services?	**Yes** ☐	**No** ☐

Medical History Click here to enter text.

Psychiatric History Click here to enter text.

Current Medications Click here to enter text.

If Inpatient Current Date Of Admission Click here to enter text.

ASSESSMENT (5)

RISK FACTORS

Medical Stability ☐ **Suicidal Ideation** ☐ **Deliberate Self-Harm** ☐

Substance Misuse ☐ **Suicide Intent** ☐ **Other (e.g. aggression)** ☐

Risk Evaluation (summation) Click here to enter text.

Support Agencies / Other Clinicians Involved Click here to enter text.

RECOMMENDATIONS

FOR WAEDOCS CLINICIANS ONLY

General Comments Click here to enter text.

WAEDOCS Guidelines ☐ RANZCP Guidelines ☐ Website Links ☐ Urgent Medical Ax ☐

Present to ED ☐ Present to GP ☐ Community MH for Ax ☐ Use of MHA ☐ General Nursing ☐

Behaviour Mx General ☐ Behaviour Mx MH ☐ Feeding Route ☐ DT General ☐

Catchment Advice ☐ Care Setting Advice ☐

Clinicians To Be Involved Nurse Practitioner ☐ Snr Dietitian ☐ CL Psychiatrist ☐

Medical Consultant ☐ Psychologist ☐ MH CNS ☐ PS Clinician ☐

Referral Entered into PSOLIS ☐ Date Click here to enter text. Start Time Click here to enter text. Finish Time Click here to enter text.

Assessment ☐ Liaison Other ☐

Entered Team Database ☐ Date Click here to enter text. Whom Click here to enter text.

WAEDOCS Clinician Name Click here to enter text. **Signature**