Statewide Eating Disorder Service (SEDS) Medical Practitioner Referral Form

Please complete and return via fax Phone: (08) 7117 8800 Fax: (08) 7117 8844

I am referring this patient to a multidisciplinary subspecialist tertiary care mental health eating disorder service for assessment and evidence based treatment planning. I understand that the patient will receive a care plan and treatment options which may be provided by SEDS or external treatment providers. I understand that all SEDS patients need to be in the care of an appropriate medical practitioner for physical health management and ongoing care

Client Information

Please note this referral will not be actioned by us until we receive the required information.
ALL sections must be completed.

Name: ..... Male ☐ or Female ☐ DOB: .....

Address: .....

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

Telephone – Home: ..... Mobile: .....

I confirm the patient has consented to this referral ☐

Medicare Number: ..... Expiry: ..... Ref Number: .....

If a Minor: Parent/Guardian name: .....

Telephone – Home: ..... Mobile: .....

Medical Practitioner Information

Name: .....

Name of Practice: .....

Address: .....

Contact – Phone: ..... Fax: .....

I am a GP ☐ / Other Specialist ☐ (Specify): ..... I will be providing ongoing care ☐

/ or Dr ..... (GP/other) will provide ongoing care ☐

Other Services/Clinicians Involved in Patient Care

Name	Organisation	Profession	Contact Number

Presenting Issue: (include onset, course, previous treatment and response to previous treatment)

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Eating Disorder Symptoms:

Restricting Food	Yes ☐	No ☐	diet:
Binge Behaviour	Yes ☐	No ☐	frequency:
Vomiting	Yes ☐	No ☐	frequency:
Exercise	Yes ☐	No ☐	type and time:
Laxative Use	Yes ☐	No ☐	drug(s), quantity, frequency:
Other (e.g. supplements)	Yes ☐	No ☐	please specify:

Weight Hx:

Current Weight ..... kg, Height: ..... cm, BMI: ..... kg/m^2 Highest weight: ..... kg Date: ...../...../.....

Rate of recent weight change: ..... Lowest weight: ..... kg Date: ...../...../.....

Amenorrhea: Yes ☐ / No ☐ / Unknown (e.g. on contraceptive) ☐ / Never menstruated ☐ / NA ☐

Diagnoses: (Please attach any relevant reports, discharge summaries, or other information)

Eating Disorder:

..... Treatment Hx: .....

Other Psychiatric and/or Substance Use Issues:

..... Treatment Hx: .....

..... Treatment Hx: .....

..... Treatment Hx: .....

If Substance Use Problems: Please specify past and current use, drug, frequency, duration, route, and last use

.....

Medical and Surgical Diagnosis:

..... Provisional ☐ / Confirmed ☐

Provisional ☐ / Confirmed ☐

Social Problems and Stressors:

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Medications: (please add additional sheet if needed)

Name	Indications	Dose	Frequency	Prescribed by	Duration

Physical Examination on ..../..../....

	Lying	Standing
Heart Rate	bpm	bpm
Blood Pressure	mmHg	mmHg

Temperature: ..... °C

ECG: conducted/ordered *(please forward results when available)*

Investigations: (RESULTS NEED TO BE CURRENT (E.G. CONDUCTED WITHIN THE LAST MONTH))

Please conduct the following investigations (indicate with a tick or cross) and forward results when available.
Please note this referral will not be actioned by us until we receive the required information.
Please indicate are the results attached ☐ / ordered and to be forwarded to SEDS by GP when available ☐

Required Analysis:

- ☐ CBE
- ☐ LFTs, U&E, Uric Acid, Bicarb, Glu
- ☐ Ca, Mg, PO4, Zn
- ☐ CK
- ☐ Fe studies
- ☐ B12/Folate/Vit D
- ☐ TFT
- ☐ Lipids

Further Investigations: *(Conduct if indicated)*

- ☐ DEXA Scan
- ☐ Other: .....

*Please see "**Brief Guide to the Medical Monitoring of Patients with an Eating Disorder**" for further information*

Mental State Examination:

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Current Risk Assessment for Suicide and Self Harm: (this MUST be performed for us to accept and triage your referral correctly)

Date when performed: / /

Details: .....

Please note: if there are immediate concerns or high risk, please contact Mental Health Triage on 13 14 65 or have the patient present to the local emergency department. SEDS is not an acute service, and cannot respond to immediate, high risk.

Any additional comments:

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Desired outcome of referral to SEDS: (consider advice needed, assessment, treatment planning, ongoing care required)

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Medical Practitioner Acknowledgement:

☐ As the referring medical practitioner/GP I am aware the patient requires ongoing physical health care and that I will be providing this or that I have made arrangements for another medical practitioner to provide this care. SEDS is unable to provide this service.

☐ I understand that my patient may be seen by one or both of the Psychiatrists at SEDS and I provide a referral under Medicare provisions (Items 296 or 306)to assure ongoing outpatient care options under their SA Health Rights to Private Practice. > Referral to Dr Randall Long > Referral to Dr Yasna Petrunic > Referral to Dr Dudridee Charoenporn

Sign: ..... **Date:** / / **Provider Number:** .....

Now, please return to SEDS via fax – ~~(08) 8198 0899~~. You will receive confirmation once your referral is received. Please contact us if you don't receive confirmation.