ACT Government | Canberra Health Services

Child and Adolescent Mental Health Service

EATING DISORDERS CLINICAL HUB REFERRAL

Complete details or affix label

MRN: _____

Family name: _____

Given names: _____

DOB: _____ Sex: _____

* 2 5 0 8 7 *

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Please provide as much information as possible to avoid delays in the referral process and to assist with triage. If you are GP please complete pages 1-4 of this form. If you are not a GP please complete pages 1-3 of this form. This form is not appropriate for referral for inpatient services for the medically unstable client.

Details of the person being referred

Surname: _____ First name: _____

DOB: ____ / ____ / ____ Gender: _____

Address: _____

Contact number: _____ Primary language: _____

Interpreter required: ☐ Yes ☐ No

Next of Kin *(parent/carer details are required if person is under 18, unless they are living independently)*

Surname: _____ First name: _____

Contact number: _____ Relationship: _____

Surname: _____ First name: _____

Contact number: _____ Relationship: _____

What are you seeking from the referral?

If you are seeking medical inpatient support please direct your patient to the emergency department. To contact The Canberra Hospital please call (02) 5124 0000. To contact Calvary Public Hospital please call (02) 6201 6111. If this is a Medical Emergency please call 000, if it is a Mental Health Crisis please call Access Mental Health on 1800 629 354

☐ General assessment and support
☐ Psycho-social assessment and treatment recommendations
☐ Individual treatment - Cognitive Behavioural Therapy (CBT)
☐ Family Based Treatment (FBT)
☐ Parent/carer education group
☐ Dietitian assessment and review
☐ Other: *(please state)* _____

Anthropometry

Current weight: _____ kg Current height: _____ cm BMI: _____ kg/m^2

Total weight: ☐ loss ☐ gain _____ kg

Over what time frame: _____ ☐ weeks ☐ months

Is weight (loss/gain) still occurring: ☐ Yes ☐ No If yes, at what rate per week: _____ kg

Eating Disorder Symptoms *(tick if present)*	Duration of symptoms *(i.e. # of months/years)*	Frequency of symptoms *(i.e. # of times a week)*
☐ Restrictive eating *(persistent restriction of energy intake below requirements)*		
☐ Binge eating *(eat a larger amount of food than normal and loss of control over eating)*		
☐ Vomiting *(self-induced)*		
☐ Laxative use		
☐ Excessive exercise *(exercising in a driven way for the purpose of weight loss)*		
☐ Other		

Mental Health Information

☐ Anxiety ☐ Obsessive compulsive disorder ☐ History of trauma
☐ Autism spectrum disorder ☐ Borderline personality disorder ☐ Depression
☐ Other: _____

Issues of Risk

Self harm behaviours	☐ None	☐ Current	☐ In the past	
Thoughts of suicide	☐ None	☐ Current	☐ In the past	
Suicidal actions	☐ None	☐ Current	☐ In the past	
Assessment of current level of risk	☐ None	☐ Mild	☐ Moderate	☐ High

How are current risk issues being managed *(if applicable)*

_____

_____

Please note that the Clinical Hub is not a crisis service - if your patient is in mental health crisis, please contact an appropriate service (e.g. Access Mental Health - on 6205 1065 or 1800 629 354)

Please provide information including:

Alcohol/drug: _____

Substance abuse: _____

Patient/Family/Carer/Guardian motivation to engage in treatment: _____

Other Services/Private Clinicians/Treating teams that are currently or recently involved in care

Name	Organisation	Profession	Contact number

Any other relevant information: *(e.g. study/work, housing, supports)*

_____

_____

_____

_____

_____

_____

_____

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_____

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25087(0123)

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Child and Adolescent Mental Health Service

EATING DISORDERS CLINICAL HUB REFERRAL

Complete details or affix label

MRN: _____

Family name: _____

Given names: _____

DOB: _____ Sex: _____

Who does the Eating Disorders Program (EDP) and Short Term Recovery Intervention for Disordered Eating (STRIDE) provide treatment for?

EDP and STRIDE offer specific, time limited, evidence based treatment, including Family Based Treatment and Cognitive Behaviour Therapy. The following are taken into consideration when deciding whether a referral to EDP or STRIDE will be the most helpful intervention for the person's circumstances.

- Primary presenting issue is an eating disorder (Anorexia Nervosa, Bulimia Nervosa, Other Specified Eating Disorder).
- BMI between 15 and 40 (people who present with a BMI below 15 usually require a higher level of care than is provided at EDP or STRIDE)
- Please note for clients under 18 years of age where possible and unless otherwise indicated we require a carer or parent to be engaged in treatment.
- If the client is an adult (over 18) then they must be motivated to engage in treatment for their eating disorder
- A current resident of the ACT
- Regularly engaged with their GP for medical monitoring
- Medically stable

The current treatment options offered by EDP and STRIDE are not appropriate interventions for people who present with a feeding disorder including Avoidant Restrictive Food Intake Disorder Withdrawal (ARFID), Pica, Rumination Disorder.

Acknowledgement

I *(name of person being referred)* _____

- I acknowledge the referral to the Eating Disorders Clinical Hub.
- I acknowledge that the Eating Disorders Clinical Hub will talk to me about my eating concerns and recommend treatment based on this assessment. Treatment recommendations may include a referral to public eating disorder services (Eating Disorders Program, STRIDE), private providers, other community or public mental health services, inpatient services, or back to my GP.
- I can withdraw this referral at any time.
- I acknowledge that the Eating Disorders Clinical Hub may be contacting my treating team, such as my GP, psychologist, dietitian and other services involved in my care as nominated above to assist in staff understanding my circumstances and making appropriate recommendations about treatment for my eating difficulties.

Client/carer *(if client is under 18 years)* signature _____ date

Client under 18 may sign and acknowledge the referral if they are considered a mature minor.

Referrer Details

Stamp:

Surname: _____

First name: _____

Position: _____

Provider number: _____

Service/Practice: _____

Phone: _____ Fax: _____

Email: _____ Signature: _____

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Medical Practitioner to complete

Treatment guidelines recommend that all patients with an eating disorder have a medical assessment, including recent pathology (see below), along with ongoing regular medical monitoring during treatment. The following is required to be completed by the medical practitioner to progress the referral.

Medical History

(including allergies, IBS, Crohns, Coeliacs, Diabetes, Pregnancy, Food intolerances/allergies, Asthma, OCP, hospital admissions, Primary amenorrhoea/Secondary amenorrhoea - if so, how long)

Please attach a separate page if more space is required.

Current medications and dose:

Vital signs at time of consultation:

Consultation date: AVPU: _____

RR: _____ bpm SpO2: _____ % HR: lying _____ bpm standing _____ bpm

Temp: _____ °C BGL: _____ mmol/L BP: lying _____ mmHg standing _____ mmHg

Postural tachycardia > 40 bpm: ☐ Yes ☐ No Postural drop > 20 mmHg: ☐ Yes ☐ No

Please complete weight information if not provided on page 2.

Current weight: _____ kg Current height: _____ cm BMI: _____ kg/m^2

Total weight: ☐ loss ☐ gain _____ kg Patient Complaints: *e.g. dizzy* _____

Over what time frame: _____ ☐ weeks ☐ months

Is weight (loss/gain) still occurring: ☐ Yes ☐ No If yes, at what rate per week: _____ kg

Pathology results to accompany referral: ☐ Attached ☐ Requested

FBE	Fe studies	LFT	ECG
U&E, Uric Acid, Bicarb	B12/Folate/Vit D	Blood Glucose	DEXA
Ca, Mg, PO4, Zn	TFT	Lipids	

Given the medical information and attached recent pathology results included with your referral, in your clinical experience, would you assess this client as medically stable at the time of this referral: ☐ Yes ☐ No

GP Details *(if not referrer)*

Surname: _____ First name: _____

Position: _____ Provider number: _____

Service/Practice: _____

Phone: _____ Fax: _____

Email: _____

Medical Practitioner Acknowledgement

As the person's GP, I am aware that I will be considered a part of my patient's treating team and as such, I am aware that the ongoing regular medical management of my patient will remain my responsibility for the duration of this person's engagement.

Signed: _____ Date:

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Please send completed form to the Eating Disorders Clinical Hub.

Email: CHS.EDCH@act.gov.au **Fax: (02) 5124 1282** **Phone: (02) 5124 4326**