eating disorders victoria

Address: Level 2, Collingwood Football Club
Community Centre, Abbotsford Vic 3067
Ph: 1300 550 236
Fax: (03) 9417 5787
edv@eatingdisorders.org.au

Client Information

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

Name: ______________________________Male/ Female/Non Binary________________DOB:__________

Address: ____

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 weekly ☐ fortnightly ☐ monthly ☐ other ☐

OR Dr_______________________________________(GP/other) will provide ongoing care ☐

Services/Clinicians Involved in Patient Care e.g. psychological, dietetic

NAME	ORGANISATION	PROFESSION	CONTACT NUMBER

Presenting issue
(include hx of eating disorder, onset, course, previous treatment and duration)

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Eating Disorder Symptoms

Restricting Food YES ☐ NO ☐ Details:

Binge Behaviour YES ☐ NO ☐ Details:

Laxative Use YES ☐ NO ☐ Details:

Vomiting YES ☐ NO ☐ Details:

Exercise YES ☐ NO ☐ Details:

Other (e.g. Supplements) YES ☐ NO ☐ Details:

Weight Hx:

Current weight: _____kg Height_______cm BMI______kg/m2 Highest weight________ Date_____

Rate of recent weight change___________________________ Lowest weight_________ Date______

Amenorrhea: YES ☐ NO ☐ Unknown (eg.on contraceptive) ☐ Never menstruated ☐ NA ☐

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: ____ ºC

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

Investigations: (results need to be current, ie. within the last month)

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 EDV 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: ....

Current Risk Assessment for Suicide and Self Harm:

(this MUST be performed for us to accept and triage your referral correctly)

Date performed: / /

Details:____

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Please note: if there are immediate concerns or high risk, please have the patient present to the local emergency department. EDV is not an acute service, and cannot respond to immediate, high risk.

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. EDV is unable to provide this service.

Sign ______________________________________ Date / /

Provider number _____________________________

Now, please return to EDV via fax – (03) 94175787 or email reception@eatingdisorders.org.au

You will receive confirmation once your referral is received.
Please contact us if you don't receive confirmation page