Peer Mentor Program
Participant Registration Form

Basic Information	
Name:	
DOB:	Address:
Contact phone:	Email:
Gender: MALE FEMALE OTHER:	
Employment status:	Highest education level:
Country of birth:	

Eating Disorder Diagnosis
Current primary eating disorder diagnosis: Any secondary eating disorder diagnosis: BMI (if known):
Do you have any other mental health conditions (previous or current)?

Recent Treatment *This program is for adults with an eating disorder leaving hospital or intensive day program.*

Eating Disorder History
What age were you when you were diagnosed with the eating disorder?
How long have you had the eating disorder for?
What behaviours, thoughts and feelings do you have that are related to the eating disorder? What do you think brought it on? What has made the eating disorder last as long as it has?

History of medical and psychiatric treatment

Have you had medical or psychiatric admissions for an eating disorder?
If yes, how many?

When were these admissions and how long, if you can remember?

Have you had other outpatient treatment or participated in day programs before?

Have you (or do you currently) access private therapy?

History of engagement with treatment services

Have you been able to comply with the requirements of treatment?

What has worked well for you in treatment?

What hasn't worked so well for you in treatment?

Overall, how would you describe your experience of treatment?

History of Risk

Do you find that you struggle with thoughts of suicide?

Have you ever attempted suicide? (if so, when was this)

Have you ever self-harmed or had thoughts of wanting to self-harm?

Any current risks?

Medical information

Are there any current medical concerns?
If yes, what are the details.

Have you (or do you currently) take any medications?

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Support Action Plan *Ongoing and regular engagement in treatment is a condition of participation in the program.* *Please note supports provided will be informed of your involvement in the program and will be contacted should risk be identified.* *If these supports change, the participant must update EDV as soon as possible.*	
GP / Primary treating clinician	
Name:	Service/organisation (if applicable):
Phone:	Email:
Consent to share information form completed ☐	
Mental Health Practitioner **(eg. psychologist, counsellor, clinical mental health social worker)**	
Name:	Service/organisation (if applicable):
Phone:	Email:
Consent to share information form completed ☐	
Office use only: Consent to share information form received Date:	
Personal support (family/friend/colleague)	
Name:	Relationship:
Phone:	Email:
Consent to share information form completed ☐	

Matching information: Tell us a little bit about you
Details provided in this section will help to guide the matching process along with other organisational considerations.

Why do you want to participate in the Peer Mentoring Program?

What does a Peer Mentor need to understand about you and your current values and goals?
Think about whether you want to work with someone who's similar or different to you,
What kind of things or people inspire, encourage and motivate you to continue in your recovery?

Tell us a little about your interests and likes?
Think about movies, music, activities, what you do in your spare time.

Consider the following and rate how important they are to you (circle your answers).

	I would prefer to be matched with someone who is…			How important is this to you?		
Age	Close to my age	Older	Younger	Not very	Somewhat	Very
Gender	Same gender	Different from me		Not very	Somewhat	Very
ED history	Similar diagnosis	Different history/diagnosis		Not very	Somewhat	Very
Location	In my neighbourhood	From a different area		Not very	Somewhat	Very

What days and times are you available to meet with your Mentor?
Think about any commitments/appointments/what works best for you.

In signing this form, I have to the best of my knowledge provided information that is true and correct and I am agreeing to be a participant in the Peer Mentoring Program.

Signed (participant): Date:

EDV office received:

Signed (staff): Date:

Please return to EDV, attention to Peer Mentoring Program Coordinator, fax (03) 9417 5787 or email Rachael.duck@eatingdisorders.org.au or for further info call 1300 550 236

Peer Mentor Program
Request to share information form

Please note you will need to fill out one of these consent forms for each of your contacts listed on the registration form.

I, *(print name)* authorise EDV staff to share and receive detailed information about me with the following people: **Signed:** **Date:**
Role: *(GP, Psychologist, counsellor, clinical mental health social worker, personal/family support)*
Name:
Contact number:
Email:
Notes/Information about this person:
EDV staff: *Date received:*

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