Advanced Psychology Services

REFERRAL FORM

Treatment of Eating Disorders

To be completed by a Medical Doctor or other Health Professional. Please consider whether the patient is eligible for a Mental Health Care Plan or Eating Disorder Treatment Plan through Medicare.

All sections must be completed before the referral can be processed.

1. CLIENT INFORMATION

Last Name **First Name** **Middle Name**

Address:

Date of Birth: **Age:**

Gender: ☐ Female ☐ Male ☐ Other /Prefer not to say

Phone: **Email:**

Aboriginal or Torres Strait Islander? ☐ Yes ☐ No ☐ Prefer not to say **Previous patient of Advanced Psychology Services?** ☐ No ☐ Yes — approx. when:

IF CLIENT IS UNDER 18 YEARS

Parent/Guardian Name:

Phone: **Email:**

School: **Year Level:**

2. REFERRER INFORMATION

Referrer Name: **Position / Title:**

Phone: **Fax:** **Practice / Clinic:**

☐ I confirm the patient / guardian has been informed of and has consented to this referral.

3. REFERRAL REQUEST — PSYCHOLOGIST AND/OR DIETITIAN

Please indicate which service(s) you are referring for:

☐ Psychologist only
☐ Both Psychologist and Dietitian

Important: A psychologist must be involved in the client's care to access our Dietitian services.

GP Resource — Unsure About Medical Status or Eating Disorder Screening?
The **Statewide Eating Disorders Service (SEDS)** provides free consultation and support to GPs and health professionals in South Australia who are uncertain about a patient's medical stability, risk level, or whether an eating disorder may be present.
SEDS can advise on screening tools (e.g. SCOFF, EDE-Q), medical monitoring parameters, and appropriate referral pathways. Contact SEDS at:
www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/mental+health+and+drug+and+alcohol+services/mental+health+services/statewide+specialist+services/eating+disorder+service/statewide+eating+disorder+service/statewide+eating+disorder+service

4. Presenting eating disorders symptoms

Currently an inpatient? ☐ Yes ☐ No **If yes, where:**

Suitable for outpatient treatment (medically stable)? ☐ Yes ☐ No ☐ Unknown

Behaviour	Present?	Comments (e.g., extent, frequency, duration of symptoms, recent changes)
Restricting food intake	☐ Yes ☐ No	
Binge eating	☐ Yes ☐ No	
Vomiting	☐ Yes ☐ No	
Laxative misuse	☐ Yes ☐ No	

Excessive / compulsive exercise	☐ Yes ☐ No	
Amenorrhoea	☐ Yes ☐ No	
Other:		

4A. MEDICAL STATUS

Current Weight (kg) & Date Taken	Height	BMI	Weight Changes (last 6 months)

Highest Weight (kg) & Date Taken		Lowest Weight (kg) & Date Taken	

Medical Complication	Present?	Details / Notes
Fainting / syncope	☐ Yes ☐ No	
Dizziness / orthostatic symptoms	☐ Yes ☐ No	
Cardiac concerns (e.g., arrhythmia, chest pain)	☐ Yes ☐ No	
Electrolyte imbalance	☐ Yes ☐ No	
Other medical concern:	☐ Yes ☐ No	

Medical Risk Indicators (tick all that apply):

☐ Rapid weight loss (e.g., >1 kg/week or significant % body weight)	☐ BMI <17 (adult) or below 2nd percentile (adolescent)
☐ Clinical concern regardless of BMI	Additional notes:

4B. DIETETIC INFORMATION *(GP to complete only if known)*

Dietetic Area	Present?	Details / Notes
Brief dietary intake overview (typical daily intake)	☐ Yes ☐ No	
Food rules / rigid food patterns	☐ Yes ☐ No	
Known allergies or intolerances	☐ Yes ☐ No	
Gastrointestinal symptoms (e.g., bloating, constipation, reflux)	☐ Yes ☐ No	
Exercise patterns (type, frequency, intensity)	☐ Yes ☐ No	

5. EATING DISORDER TREATMENT HISTORY

Treatment Setting	Previous?	Currently Involved?	Comments on Treatment Response
Hospital / Inpatient program	☐ Yes ☐ No	☐ Yes ☐ No	
Medical outpatient (e.g., paediatrician)	☐ Yes ☐ No	☐ Yes ☐ No	
Psychologist	☐ Yes ☐ No	☐ Yes ☐ No	
Psychiatrist	☐ Yes ☐ No	☐ Yes ☐ No	
Dietitian	☐ Yes ☐ No	☐ Yes ☐ No	
Other:			

Previous contact with the following services (tick all that apply):

☐ Statewide Eating Disorder Service (SEDS)	☐ Statewide Paediatric Eating Disorders Services (SPEDS)
☐ Women's & Children's Hospital (mental health / eating disorders)	☐ Child and Adolescent Mental Health Service (CAMHS)
☐ Department for Child Protection (DCP)	☐ Other:

6. OTHER PSYCHIATRIC & SUBSTANCE USE ISSUES

Condition (e.g., depression, anxiety, PTSD, substance use)	Current?	Treatment History / Notes
Depression	☐ Yes ☐ No	Receiving treatment: ☐ Yes ☐ No Details:
Anxiety	☐ Yes ☐ No	Receiving treatment: ☐ Yes ☐ No Details:
Bipolar Disorder	☐ Yes ☐ No	Receiving treatment: ☐ Yes ☐ No Details:
PTSD / Trauma	☐ Yes ☐ No	Receiving treatment: ☐ Yes ☐ No Details:
OCD (Obsessive Compulsive Disorder)	☐ Yes ☐ No	Receiving treatment: ☐ Yes ☐ No Details:
BPD (Borderline Personality Disorder)	☐ Yes ☐ No	Receiving treatment: ☐ Yes ☐ No Details:
Schizophrenic Disorders (e.g., schizophrenia, schizoaffective)	☐ Yes ☐ No	Receiving treatment: ☐ Yes ☐ No Details:
ADHD (Attention Deficit Hyperactivity Disorder)	☐ Yes ☐ No	Receiving treatment: ☐ Yes ☐ No Details:
Autism Spectrum Disorder (ASD)	☐ Yes ☐ No	Receiving treatment: ☐ Yes ☐ No Details:
Alcohol Abuse / Dependence	☐ Yes ☐ No	Receiving treatment: ☐ Yes ☐ No Details:
Drug Abuse / Dependence	☐ Yes ☐ No	Receiving treatment: ☐ Yes ☐ No Details:
Other (please specify):	☐ Yes ☐ No	Receiving treatment: ☐ Yes ☐ No Details:

Psychiatric History & Current Engagement (other conditions, apart from the eating disorder):

Question	Response / Details
Previous psychiatric history (hospitalisations, diagnoses, episodes)?	☐ Yes ☐ No Details:
Currently actively engaged with another psychology service?	☐ Yes ☐ No Provider / Service name:
Currently under the care of a psychiatrist?	☐ Yes ☐ No Psychiatrist name:
Current psychiatric medications (name, dose, prescriber):	☐ None Details:

7. SELF-HARM & RISK

In the last 3 months:

Suicide attempt: ☐ Yes ☐ No **Non-suicidal self-harm:** ☐ Yes ☐ No

Details / method / frequency:

Please note: If the patient has made a suicide attempt within the last 3 months, we recommend seeking an alternative treatment setting and re-referring following a period of at least 3 months with no suicide attempt and a reduced level of risk.

Prior to the last 3 months:

History of suicide attempt? ☐ Yes ☐ No **History of non-suicidal self-harm?** ☐ Yes ☐ No

If yes, when / details:

Referrer's current assessment of self-harm / suicide risk level:

☐ Low	☐ Moderate	☐ High	☐ Unknown / Difficult to assess

8. PAEDIATRICIAN INVOLVEMENT

Advanced Psychology Services recommends that a paediatrician is involved in the care of any client engaging in Family Based Therapy (FBT) whilst receiving treatment through our service. If your client is undertaking or expected to undertake FBT, please ensure a paediatrician referral is made prior to or concurrent with this referral.

Is a paediatrician currently involved? ☐ Yes ☐ No ☐ Referral in progress

Current paediatrician (if known):

9. ADDITIONAL INFORMATION — CHILD / ADOLESCENT (UNDER 18)

Do parents/guardians live together? ☐ Yes ☐ No ☐ Shared custody arrangement

Is there a court order in place (e.g., parenting order, family law order)? ☐ Yes ☐ No ☐ Unknown If yes, please attach a copy or provide details:

Carer / family involvement in treatment: ☐ Fully supportive ☐ Partially involved ☐ Not involved ☐ Unknown

Cultural considerations relevant to treatment (e.g., language, cultural beliefs, family structure):

10. ATTACHMENTS

Please tick all documents attached to this referral:

☐ Eating Disorder Treatment Plan	☐ SEDS report / assessment
☐ Psychiatrist reports	☐ Discharge summary
☐ Paediatrician reports	☐ Dietitian reports
☐ Mental Health Care Plan	☐ Other

Any further information you wish to provide:

☐ Ongoing medical / psychiatric care will be provided by myself (referring practitioner)

☐ **Other (please name):**

I understand that for referrals with significant comorbidity or self-harm / risk issues, ongoing psychiatric care will need to be maintained elsewhere so that our clinic can focus primarily on the treatment of the eating disorder.

Signature of Referrer: **Date:**

IMPORTANT NOTICE — FEE FOR SERVICE

Advanced Psychology Services is a private clinic. All appointments are fee for service. Sessions are not bulk billed and are not provided free of charge.
Fees are payable at the time of each appointment. Please discuss fees with our administration team prior to the first appointment.
Concession Rate: A reduced concession rate is available for holders of a current Government Health Care Card (e.g. Centrelink Health Care Card, Pensioner Concession Card, or Commonwealth Seniors Health Card). Clients wishing to access the concession rate must present a valid card at or before their first appointment.
Please note: Medicare rebates may be available for eligible clients holding a valid Mental Health Care Plan or Eating Disorder Treatment Plan issued by their GP. Please speak with our administration team for further information.

Please return this referral form via: Email: info@advancedpsychology.com.au | Fax: (08) 8227 0937