Advanced Psychology Services

Treatment of Eating Disorders

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REFERRAL FORM TO ADVANCED PSYCHOLOGY SERVICES

To be completed by a Medical Doctor or other Health Professional. Please consider if patient is eligible for a Mental Health Care Plan.

Client Information

Name: ____
Last First Middle

Address: ____

Age: _______________ Date of Birth: __________________________ Gender: F ❑ M ❑

Telephone Number: ________________________ Email: ________________________________

If Under the age of 18 years

Parent/Guardian name:____

Telephone Number: ________________________ Email: ________________________________

Is the person a previous patient of Advanced Psychology Services? No ❑ Yes ❑ When ___________________________

Referrer information

Name:____ Position:____

Contact number ______________________________________ Fax: ______________________________________

I confirm the patient/guardian has consented to this referral ❑

Presenting eating disorder symptoms

Is this client a current inpatient? Yes ❑ No ❑ If yes, where:_____________________

Behaviours		Comments (e.g., extent, frequency)
Restricting food intake	Yes ❑ No ❑	
Binge eating	Yes ❑ No ❑	
Vomiting	Yes ❑ No ❑	
Laxatives	Yes ❑ No ❑	
Exercising excessively	Yes ❑ No ❑	
Amenorrhea	Yes ❑ No ❑	
Other:		

Current weight ________kg Height________ m BMI_______

Weight history

Highest weight ________kg When________ Lowest weight ________kg When________

Weight changes in last 6 months? ____

This patient is suitable for outpatient treatment (e.g., medically stable) Yes ❑ No ❑ Unknown ❑

Eating disorder treatment history

		When	Currently involved?	Any comments on treatment response
Hospital program	Yes ❑ No ❑			
Medical outpatient (e.g., paediatrician)	Yes ❑ No ❑			
Psychologist	Yes ❑ No ❑			
Psychiatrist	Yes ❑ No ❑			
Dietician / Other	Yes ❑ No ❑			

Other psychiatric or substance use issues (current or past, e.g., depression, anxiety)

__________________________Current? Yes ❑ No ❑ Treatment Hx:______________________________

__________________________Current? Yes ❑ No ❑ Treatment Hx:______________________________

__________________________Current? Yes ❑ No ❑ Treatment Hx:______________________________

Self-harm and risk issues

Has the person self-harmed in the last 3 months?

Suicide attempt: Yes ❑ No ❑ Non-suicidal self-harm: Yes ❑ No ❑

Details ____

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

Prior to the last 3 months, does the patient have a history of suicide attempts or other self-harm?

Suicide attempt: Yes ❑ No ❑ Non-suicidal self-harm: Yes ❑ No ❑

When?____

What is your assessment of the patient's current level of self-harm risk?

____

Any further information you wish to provide?

____

____

____

Please specify:

I will be providing ongoing medical/psychiatric care ❑

Or __________________________________ will provide ongoing medical/ psychiatric care ❑

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

Signed (referrer):________________________ Dated: ______________

Please return referral form via email info@advancedpsychology.com.au or fax (08) 8227 0937

GPs may wish to attach a Mental Health Care Plan.

Office Use Only

Date Received:		Referrer Informed of Outcome:	