Statewide Eating Disorder Service (SEDS) Medical Practitioner Referral Form

Enquiries (08) 7117 8800

I am referring this patient to a multidisciplinary subspecialist tertiary care mental health eating disorder service for assessment and evidence based treatment planning. I understand that the patient will receive a care plan and treatment options which may be provided by SEDS or external treatment providers. I understand that all SEDS patients need to be in the care of an appropriate medical practitioner for physical health management and ongoing care

Patient Information

Name: ..... Male ☐ Female ☐ Other ☐ DOB: .....

Address: .....

Preferred Language (& dialect): ..... Interpreter Required: Yes ☐ / No ☐

Telephone – Home: ..... Mobile: ..... Email: .....

I confirm the patient has consented to this referral ☐

Medicare Number: ..... Expiry: ..... Ref Number: .....

If a Minor: Parent/Guardian name: .....

Contact: .....

Medical Practitioner Information

Name: .....

Name of Practice: .....

Address: .....

Contact – Phone: ..... Fax: .....

I am a GP ☐ / Other Specialist ☐ (Specify): ..... I will be providing ongoing care ☐

/ or Dr ..... (GP/other) will provide ongoing care ☐

Other Services/Clinicians Involved in Patient Care

Name	Organisation	Profession	Contact Number

Presenting Issue: (include onset, course, previous treatment and response to previous treatment)

Eating Disorder Symptoms:

Restricting Food Yes ☐ No ☐ diet:

Binge Behaviour Yes ☐ No ☐ frequency:

Vomiting Yes ☐ No ☐ frequency:

Exercise Yes ☐ No ☐ type and time:

Laxative Use Yes ☐ No ☐ drug(s), quantity, frequency:

Other (e.g. supplements) Yes ☐ No ☐ please specify:

Weight Hx:

Current Weight ..... kg, Height: ..... cm, BMI: ..... kg/m^2 Highest weight: ..... kg Date: ...../...../.....

Rate of recent weight change: ..... Lowest weight: ..... kg Date: ...../...../.....

Amenorrhea: Yes ☐ / No ☐ / Unknown (e.g. on contraceptive) ☐ / Never menstruated ☐ / NA ☐

Diagnoses: (Please attach any relevant reports, discharge summaries, or other information)

Eating Disorder:

..... Treatment Hx: .....

Other Psychiatric and/or Substance Use Issues:

..... Treatment Hx: .....

..... Treatment Hx: .....

..... Treatment Hx: .....

If Substance Use Problems: Please specify past and current use, drug, frequency, duration, route, and last use

.....

Medical and Surgical Diagnosis:

..... Provisional ☐ / Confirmed ☐

Provisional ☐ / Confirmed ☐

Social Problems and Stressors:

.....

Medications: (please add additional sheet if needed)

Name	Indications	Dose	Frequency	Prescribed by	Duration

Physical Examination on ...../...../.....

If there are immediate concerns, please have the patient present to the Emergency Department of their local hospital

	Lying	Standing
Heart Rate	bpm	bpm
Blood Pressure	mmHg	mmHg

Temperature: ..... °C

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

Finger Prick Glucose:

Investigations: **(RESULTS NEED TO BE CURRENT – E.G: CONDUCTED WITHIN THE LAST MONTH)**

Please conduct the following investigations (indicate with a tick ✔ or cross ✗) and forward results when available.
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 SEDS 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: .....

*Please see "**Brief Guide to the Medical Monitoring of Patients with an Eating Disorder**" for further information*

Mental State Examination:

.....

Current Risk Assessment for Suicide and Self Harm: (this must be performed for us to accept and triage your referral correctly)

Date when performed: / /

Details: .....

Please note: if there are immediate concerns or high risk, please contact Mental Health Triage on 13 14 65 or have the patient present to the local emergency department. SEDS is not an acute service, and cannot respond to immediate, high risk.

Any additional comments:

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Desired outcome of referral to SEDS: (consider advice needed, assessment, treatment planning, ongoing care required)

.....

SEDS can generate an Eating Disorder Plan if indicated.
Please advise if there is a current EDP under Medicare Items 90250 – 90257. ☐ Yes ☐ No

Medical Practitioner Acknowledgement:

By signing this form I am making a Medicare referral to Dr Randall Long AND Dr Yasna Petrunic AND Dr Dudridee Charoenporn who may use their Rights of Private Practice to render Medicare services including those item numbers to facilitate further Eating Disorder Plan Care.

Sign: ..... **Date:** / / **Provider Number:** .....

Now, please return to SEDS via email health.fmcsedsclinician@sa.gov.au (preferred) or Fax: (08) 7117 8844.
You will receive confirmation once your referral is received. Please contact us if you don't receive confirmation.