**EATING DISORDERS ACCESS TRIAL OPEN REFERRAL FORM**

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| Referral form | Eating Disorders Access Assessment  Eating Disorders Access Treatment | | | | | | |
| **1. Patient Details** | | | | | | | |
| First Name |  | | | Last Name | |  | |
| Date of Birth | Click here to enter a date. | | | Age | |  | |
| Gender | Choose an item. | | | | | | |
| Medicare Number |  | | | Private Health Insurance | |  | |
| Occupation/Benefit Status | Choose an item. | | | | | | |
| Indigenous Status | Choose an item. | | | | | | |
| First Language |  | | | Is an interpreter required? | | Choose an item. | |
| Address |  | | | | | | |
| Postcode |  | | | Preferred Contact No | |  | |
| Is Patient aware of this referral? | | Yes No | Does Patient agree? | | Yes No | |  |
| **2. Referring Clinician** | | | | | | | |
| Name |  | | | Medicare Provider Number | |  | |
| Name and Address of Practice |  | | | | | | |
| Contact Phone |  | | | Fax Number | |  | |
| **3. Reason for Referral** (Please indicate suspected diagnosis, duration, symptoms, precipitant. Include computer generated summary if available) | | | | | | | |
|  | | | | | | | |
| **4. Brief Clinical History**/additional relevant information. (Please briefly describe physical assessment and medical history or confirm computer generated summary and investigations | | | | | | | |
|  | | | | | | | |
| **5. Medical Practitioner Acknowledgement** | | | | | | | |
| I refer my patient for assessment and treatment of a suspected eating disorder by  The service providers named below:  Psychologists, Dietitians and eligible mental health professionals registered with the Eating Disorders Access Project | | | | | | | |

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| **As treating GP/Paediatrician by completing this referral form I acknowledge that:** | | | | | | | |
| * I have medically assessed this patient and I have completed/ordered the investigations outlined in this referral form * I have arranged appropriate medical care where any of the patient's physical assessment outcomes sit outside the critical values outlined in this referral form * Patient does not require immediate hospital admission as per Queensland Eating Disorder Service Guidelines (refer to Medical Assessment form) * I will provide ongoing and regular medical monitoring for this patient or I have arranged for another medical practitioner to provide this care * I am responsible for ensuring copies of all investigation results, not more than 2 weeks old, are faxed to 07 5519 3425. | | | | | | | |
| GP Signature: | | |  | Date: | | Click here to enter a date. | |
| **Please send referrals to:** | | | | | | | |
| Fax: 07 5502 7414 or Email: [health@artius.com.au](mailto:health@artius.com.au) Secure message delivery via Healthlinks (**artiushl)** and Medical Objects to **(Artius)** | | | | | | | |
| Shared Team Care | | | | | | | |
| Please complete this page if the patient has other people involved in their care or treatment of their eating disorder. | | | | | | | |
| Service Providers/Clinicians to be involved in patient care: | | | | | | | |
| **Name** | | | **Organisation** | **Professional Care Context** | | | **Contact Number** |
|  | | |  | GP or Paediatrician | | |  |
|  | | |  | Psychological Therapist | | |  |
|  | | |  | Dietetic Support | | |  |
|  | | |  | Peer Support | | |  |
|  | | |  | Psychiatrist | | |  |
| **General Practitioner Team Care – Please Upload with Referral** | | | | | | | |
| Does the patient have a GP Management Plan (item 721) | | | | Choose an item. | | | |
| Does the patient have a Team Care Arrangement (item 723) | | | | Choose an item. | | | |
| **Family or Supporter** | | | | | | | |
| First Name: |  | | | Last Name: |  | | |
| Relationship to patient: | |  | | | | | |
| Contact Phone: | |  | | | | | |
| Does the patient agree to the involvement of this person in their assessment & treatment | | | | | | | Choose an item. |