



Victorian Centre of Excellence in Eating Disorders

C/o Post Office, Royal Melbourne Hospital 3050

Telephone: (03) 8387 2673

Fax: (03) 8387 2667

Email: ceed@mh.org.au

Web: www.ceed.org.au

Dear Health Professional,

Thank you for contacting the Specialist Consultation and Education Service of the Victorian Centre of Excellence in Eating Disorders. Please find attached a copy of our Request for Consultation and Education form.

To initiate the consultation process, please complete the forms and fax back to CEED on **(03) 8387 2667**. Complete the first page, then as relevant Forms A and / or B.

We will acknowledge your request within 48 hours, with the aim of providing a response to your request within 5 – 7 days.

Before proceeding with your consultation request please ensure you read and can agree with the following privacy and clinical responsibility positions:

Privacy Note

Information about your patient or client provided with this form and during the course of a consultation may be provided in de-identified form, to protect the privacy of your patient. However, information you provide may directly, indirectly or inadvertently disclose information about your patient or client, which may identify them. Information regarding patients who may reasonably be identified from that information is subject to the *Health Records Act 2001 (Vic)*.

Wherever possible, you should obtain the consent of your patient or client to discuss their case with CEED. Information you provide (whether or not that information identifies your patient or client) will be kept confidential by CEED.

Position of CEED on Clinical Responsibility for Patients

In the course of a secondary consultation, CEED consultants may provide information, advice and recommendations based on the clinical information you provide. Whilst every effort is made to provide accurate and pertinent information and advice, any information or advice provided by CEED is necessarily based on the clinical information you provide.

CEED emphasises that the purpose of the secondary consultation is to provide you, the treating health professional, with advice and assistance regarding the identification, treatment and management of eating disorders. The patient in respect of whom the consultation is sought remains your patient and responsibility for the ongoing clinical care of the patient remains with you at all times.

**Consultation and Education Team
Victorian Centre of Excellence in Eating Disorders**



Request for Consultation & Education

Complete and fax to (03) 8387 2667

1. Referrer Details:

Date: ___ / ___ / ___

Name: _____ Position: _____

Team: _____

Organisation/AMHS: (Select 1 only)

- Barwon
- Eastern Metro
- Gippsland
- Glenelg / South West Rural
- Goulburn & Southern (Shepparton)
- Grampians (Ballarat)
- Inner South East (Alfred)
- Inner Urban East (St Vincent's)
- Inner West (Moonee Ponds)
- Loddon Campaspe (Bendigo)
- Mid West (Sunshine)
- North East Metro
- North East Hume (Wangaratta-Wodonga)
- Northern Metro
- Northern Mallee (Mildura)
- North West Metro (Coburg)
- Orygen Youth Health
- North West Metro CAMHS (RCH)
- Peninsula (Frankston)
- Southern (Monash)
- South West Metro (Werribee Mercy)

If AMHS worker:

**Program/Department/Team:
(Select 1 only)**

- Adult Acute in pt
- Aged in pt
- APATT
- CAMHS – community
- CAMHS- in pt
- CAMHS – community & in pt
- CATT & Triage
- CCT
- CCU
- HOPS
- MST
- PMHT
- Specialist Eating Disorder Service
- Spectrum
- Dual Diagnosis Service
- Dual Disability
- CATT, Triage & CCT
- Executive/Operations Management
- Other _____

**Professional Group/Discipline:
(Select 1 only)**

- Consumer / Carer Advocate
- Management
- Medical Officer
- Dietitian
- Family Therapist
- Nurse:
 - Div 1
 - Div 2
 - Div 3
- Occupational Therapist
- Psychiatrist
- Psychologist
- Registrar:
 - Psychiatry
 - Paediatrics
 - other
- Social Worker
- Other _____

Other Organisation: _____

Address: _____

Ph: _____ mob: _____

Email: _____ fax: _____

2. Type of Request:

- Primary Consultation** - collaborative assessment of client with CEED clinician *(Complete sections 3 & 4 below, & Form A)*
- Secondary Consultation**- case discussion consultation with CEED clinician *(Complete sections 3 & 4 below, & Form A)*
- Tertiary Consultation / Service Development**- consultation focussed on service planning, structure and/or programs
(Complete sections 3 & 4 below, & Form B)
- Education and Training** *(Complete sections 3, 4 below, & Form B)*

3. Who has been involved in the discussions and the decision to make a request for consultation?

4. Who would be appropriate to be involved in the consultation? E.g. Team members, team leader, service manager or director, associated services or private practitioners, other?



Request for Consultation & Education

Form A: Primary / Secondary Consultation Request

Referrer's Name: _____ Date: _____

Client Details: Gender: _____ age: _____

Diagnosis (if known): _____

Suburb / town: _____

Other services / professionals involved in care / treatment:

1. Brief outline of the client's clinical presentation:

2. What are the key issues you are concerned about in the assessment, management or treatment of this client?

3. What are the outcomes you are seeking through requesting consultation?

I have read and agreed to the CEED covering letter regarding privacy and clinical responsibility for patients (please tick)

Fax completed Forms to CEED on: (03) 8387 2667



Request for Consultation & Education

Form B: *(please tick)*

- Tertiary Consultation / Service Development Request**
- Education & Training Request**

Referrer's name: _____ **Date:** _____

1. Please outline the Service Area / Staff group to be the focus of this consultation / training request.

2. What are the outcomes you are seeking from consultation / training?

Fax completed form to CEED on: (03) 8387 2667