RCH Eating Disorder Service Referral Form

To be completed by the referring doctor,

1. Patient Information

- Full Name: _____
- Date of Birth: _____ / _____ / _____
- Address: _____
- RCH UR Number (if known): _____
- Gender/pronouns: _____
- Medicare Number: _____
- Parent/Guardian Name (if applicable): _____
- Contact Person and Number: _____
- Indigenous Status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Non-indigenous
- Interpreter required: ☐ Yes ☐ No. Language: _____

2. Weight History

- Current Weight: _____ kg
- Pre-morbid Weight (weight prior to ED symptom onset): _____ kg
- Height: _____ cm
- BMI: _____
- Percentage Weight Loss: _____ %
- Timeframe of Weight Loss: _____ months
- Historical weights if available: _____

3. Eating Behaviours and Concerns

Tick all that apply and provide brief notes if relevant:

- ☐ Concern about weight
- ☐ Body image concerns / fear of weight gain
- ☐ Dietary restriction
- ☐ Eating rituals (e.g. eating slowly, in isolation): _____
- ☐ Weight control behaviours:
  ☐ Excessive exercise ☐ Laxative use ☐ Purging ☐ Other: _____
- ☐ Binge eating
- ☐ Additional notes: _____

4. Co-morbidities

Please tick if any are present:

- ☐ Autism
- ☐ Obsessive Compulsive Disorder
- ☐ Depression
- ☐ Self-harm / suicidality
- ☐ Other mental health / neurodevelopmental concern : _____

5. Menstrual History (for those assigned female at birth)

- Onset of Menarche: _____ years
- Last Menstrual Period: _____
- Menstrual Regularity: ☐ Regular ☐ Irregular ☐ Amenorrhoea

6. Clinical Examination

- Postural Heart Rate:
  - Lying: _____ bpm
  - Standing: _____ bpm
- Postural BP:
  - Lying: _____ / _____ mmHg
  - Standing: _____ / _____ mmHg
- Temperature: _____ °C
- **7. Investigations**

Blood Tests (tick if completed):

- ☐ FBE ☐ U&E ☐ Ca ☐ Mg ☐ PO4
- ☐ LFTs ☐ Venous Blood Gas ☐ Glucose
- ☐ ESR ☐ Thyroid Function ☐ Coeliac Screen
- ☐ Iron Studies ☐ B12 ☐ Red Cell Folate ☐ Vitamin D

- ☐ 12-lead ECG attached
- QTc (if known): _____ secs

Please attach results to referral where possible.

8. Medical Stability Checklist ☐ Resting HR ≤ 50 bpm
☐ Postural systolic drop ≥ 20 mmHg
☐ BSL < 4.0 mmol/L
☐ Potassium < 3.0 mmol/L
☐ Temperature < 35.5°C
☐ Clinical dehydration
☐ No oral intake > 48 hours
☐ Arrhythmia or QTc > 0.45s

If any of the above are present, please consider referring the patient to your local Emergency Department.

9. Current Care Team

- Paediatrician: _____
- Dietitian: _____
- Psychologist / Mental Health Support: _____
- Other Providers: _____

10. Referring GP Details

- Name: _____
- Provider Number: _____
- Clinic / Practice Name: _____
- Practice Address: _____
- Phone: _____
- Email / Fax: _____
- Doctor's Signature: _____ Date: ____ / ____ / _____
- Referral duration: ☐ 12 months ☐ Indefinite