**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 |
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| **5. Medical Practitioner Acknowledgement** |
|  I refer my patient for assessment and treatment of a suspected eating disorder by [ ]  The service providers named below: [x]  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.
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| GP Signature: |  | Date: | Click here to enter a date. |
| **Please send referrals to:** |
| Fax: 07 5502 7414 or Email: health@artius.com.auSecure 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. |