FAH067084a

Austin HEALTH

Specialist Eating Disorder Service (SEDS) Referral

U.R Number ……..

Surname ……..

Given Name(s) ……..

Date of Birth ……..

AFFIX PATIENT LABEL HERE

Dr.....

Address.....

Phone..... Fax.....

Provider No.....

Email.....

Signature.....

Date of Referral.....

.....

Home Phone.....

Mobile.....Gender.....

Medicare No.....

Carer Name……..

Carer Phone……..

Carer Email……

Physical Parameters

Weight..... kg Height.....cm

Temperature.....°C

Lying pulse..... Lying BP.....

Standing pulse..... Standing BP.....

Menstrual status.....

Diagnostics – Please attach results of the following investigations:

☐ ECG ☐ FBE ☐ UEC ☐ LFTs ☐ Ca, Mg, PO4

☐ Random glucose ☐ TFTs ☐ Iron studies

Medications

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Weight Trajectory and History

Current Eating Disorder Symptoms / Behaviours

☐ Use of laxatives ☐ Exercise

☐ Binging ☐ Other

☐ Purging / vomiting

☐ Restrict

24 hour oral intake

Physical Symptoms including Syncope

Co-morbid Mental and Physical health diagnoses

Current Risk Issues

Family / Social Situation

Treating Team (if applicable)

Please return completed forms to Mental Health Triage.

Fax to 03 9496 6926 Telephone – 1300 859 789

For referrals to Infant, Child, and Youth Mental Health please email – Paediatriceatingdisorders@austin.org.au or under18triage@austin.org.au

02/2024

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