NORTH METRO HEALTH SERVICE

NORTH METRO EATING DISORDERS SPECIALIST SERVICE

NMHS REFERRAL FORM

(Affix patient identification label here)

UMRN:
Family Name:
Given Names:
Address:
Date of Birth: Gender:

REFERRAL TO

Day Program (16+ years only)

The Day Program involves attending the following sessions four days a week (Mon-Tues-Thurs-Fri) for up to three months:

- Meal support (meals and snacks)
- Group sessions (activities, skills based, education and therapy)
- Individual sessions (key worker, dietetic, psychology, psychiatry, exercise physiologist, social work)
- Peer support worker sessions

☐ **Referral for Day Program**

Intensive Clinical Monitoring (ICM) (16+ years only)

ICM provides medical monitoring to individuals either following hospital discharge or to sustain their medical progress while they are waiting for their next phase of treatment such as entry to the day program. ICM will be held four days a week (Mon-Tues-Thurs-Fri). Clients can be seen 1-4 times a week for up to eight weeks.

☐ **Referral for ICM**

Specialist Multidisciplinary Outpatient Clinic (SMOC) (16+ years only)

This service will provide specialist support for people with eating disorders in the community. It will support the needs of service users who do not meet inclusion criteria for other eating disorder services or those with additional complex mental or physical health needs who require more specialised medical, psychiatric or dietetic input.

☐ **Referral for Psychiatry**
☐ **Referral for Physician**
☐ **Referral for Dietetics**
☐ **Referral for Exercise Physiologist**
☐ **Referral for Social Worker**

Date of referral _____

Clients contact number _____

Nominated Support Person _____

Support Persons contact number _____

Reason for SMOC Referral (not required if referral is for Day Program):

☐ Clarification of complex/co-occurring mental or physical health concerns (in addition to eating disorder)
☐ Treatment input
☐ Other: _____

Diagnosis/eating disorder concerns: _____

_____

Patient consents to referral: ☐ Yes ☐ No

Mental Health and Eating Disorder Behaviour Assessment

☐ Oral Restriction ☐ Vomiting ☐ Bingeing ☐ Over-exercising ☐ Diuretics ☐ Laxatives

Past psychiatric history: ☐ Yes ☐ No Drug & Alcohol issues: ☐ Yes ☐ No

If 'Yes' to either question, please provide further details: _____

_____

Severity of Symptoms High ☐ Moderate ☐

Readiness for Active Treatment High ☐ Moderate ☐ Low ☐

Medical Assessment, History, Medication and Allergies

Date completed _____

BP: Lying _____ Standing _____ HR: lying _____ Standing _____ BSL _____

Respiration Rate _____ Temperature _____ Amenorrhea ☐ Yes ☐ No

Blood results less than 2 weeks old attached – including LFT, UEC and FBC attached ☐ Yes ☐ No

Medical History _____

_____

Previous admissions/treatment (medical/mental health) _____

_____

Current Medications including non-prescription:_____

_____

Medication allergies or food allergies/intolerances:_____

_____

Substance use (inc. alcohol and other drugs) :_____

Initial Risk Assessment

☐ Suicidal thoughts/intent/plan: _____ Safety plan: _____

☐ Self-harm – Type: _____ Safety plan: _____

Height: _____ cm Weight: _____ kg (_____ date) BMI: _____

Weight History: _____

Nutritional intake (e.g. Numbers of meals/calories/day):

_____

Physical complications: ☐ Fainting ☐ Dizziness ☐ Chest pain ☐ Dehydration

☐ Other: _____

Community Team

GP: _____ Practice: _____ Phone:_____

GP/Practice Email: _____

Community Dietitian: _____

Community Psychologist: _____

Please list any other professionals or organisations involved in care: _____

_____

Referrer's details

Referrer's name: _____

Designation/Service: _____

Contact Number: _____ Email: _____

Please attach latest psychiatry notes if currently engaged with a Mental Health Service

Send to North Metro Eating Disorders Specialist Service (NMEDSS) via email:
referrals.NMEDSS@health.wa.gov.au

NMEDSS USE ONLY:

Date received: _____ Triage Clinician Allocated: _____

Date of Client contact: _____

Appointment Created: Yes ☐ Date of appointment: _____

No ☐ Reason: _____