EAST METRO HEALTH SERVICE **EATING DISORDER SPECIALIST SERVICE (EMEDSS)** **REFERRAL FORM** Confidential Information	SURNAME:	UMRN:
	GIVEN NAMES:	DOB: AGE:
	ABORIGINAL or TSI: Yes ☐ No ☐	GENDER:
	ADDRESS:	
	EMAIL:	PHONE:

Please call the triage officer on (08) 9224 4242 to discuss ALL referrals prior to sending.
Send this form to EMEDSSReferrals@health.wa.gov.au or fax to (08) 9224 4243

EMEDSS offers an intensive outpatient eating disorder program of combined medical monitoring and specialist multidisciplinary evidence-informed therapies including psychology and dietetics. It is important for clients and referrers to understand that the service is **time-limited to 12 weeks** and requires a **high level of commitment** and engagement from the client. The EMEDSS team will assess the needs of the client and determine who the client sees and frequency.

INCLUSION CRITERIA – all criteria must be met

☐ Consents to referral and agreeable to engaging with the service
☐ Willing to attend weekly appointments as a minimum, as determined by clinical need
☐ Aged 16 years and older
☐ Eating disorder as a diagnosis of primary concern and/or is diagnosed with an eating disorder
☐ Resides within the EMHS catchment
☐ Medically stable – can be maintained in the community or out of hospital
☐ Engaged with a GP in the community or is willing to do so on an ongoing basis

EXCLUSION CRITERIA – if any apply, please call triage officer 9224 4242

☐ Acute risk of self-harm or suicide not manageable in a community setting
☐ Active substance or alcohol use resulting in regular intoxication impacting the ability to engage effectively with EMEDSS
☐ Active psychosis

N.B. In certain circumstances, we may be able to see these patients under a shared care arrangement with a community mental health team or drug and alcohol service.

Referral completed by: ☐ **Psychiatrist** ☐ **Psychiatry Registrar** ☐ **GP**

REFERRER	Name:	Service:
	Phone:	Fax:
	Email:	
Usual GP (If different to referrer)	Name:	Practice:
	Phone:	Fax:
	Email:	
COMMUNITY SUPPORTS	Dietitian:	Clinical Psychologist:
	Psychiatrist:	Other:
NEXT OF KIN/ NOMINATED PERSON	Name:	Relation:
	Phone:	Address:
Is the client currently an inpatient? ☐ Yes ☐ No		
If YES, specify:	Hospital:	Treating Team/Ward:
	Treating Psychiatrist:	
Is the client currently active with a community mental health team? ☐ Yes ☐ No		
If YES, specify:	Clinic/Team:	
	Treating Psychiatrist:	

EATING DISORDER ASSESSMENT

Diagnosis:

☐ Dietary Restriction ☐ Vomiting ☐ Bingeing ☐ Over exercise ☐ Laxatives ☐ Diuretics/ diet pills
Provide details if ticked:

Weight history

Date:	Height: cm	Weight: kg	BMI: kgm2
Highest weight:		Lowest weight:	

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RISK ASSESSMENT	
☐ Suicidal thoughts/ intent/ plan	☐ Self- harming, specify:
☐ Impulsivity	☐ RAMP attached (not required from GPs)
☐ History or current family domestic violence	
☐ Substance use (inc. alcohol and other drugs), specify:	
Provide details if ticked & any other relevant background risk/ additional information:	

MEDICAL ASSESSMENT AND OTHER RELEVANT HISTORY			
Date of observations:		**(Required within: 48 hours if inpatient, 1 week if in community)**	
BP: Lying	Standing (3min)	HR: Lying	Standing (3min)
BSL	RR	Temp	Amenorrhea ☐ Yes ☐ No
Date of investigations:		**(Required within: 48 hours if inpatient, 2 weeks if in community)**	
☐ ECG attached			
☐ Blood results attached - FBC, LFT, UEC, Mg, Po4, Ca			
Physical concerns: ☐ Fainting ☐ Dizziness ☐ Chest pain ☐ Dehydration ☐ Other, specify:			

Past Medical History:

Psychiatric Diagnoses/History/Concerns:

Previous Admissions (Medical/Mental Health, attach discharge summary if available):

Current Medications:

☐ I understand EMEDSS does not assume clinical governance until the client has commenced treatment with the service. EMEDSS will notify the client, the GP (and the referrer if not the GP) once a client has commenced. This does not include triage appointments.

☐ **For GPs referring from the community** – I understand that in the interim, I am responsible for providing medical monitoring for the client and that I will forward observations and bloods of each medical monitoring visit to EMEDSSReferrals@health.wa.gov.au. EMEDSS recommends at least weekly monitoring or more frequently if medically indicated. A template for medical monitoring will be emailed to you.

☐ **For referrals from inpatient** – I will advise the client to make an appointment with their GP for medical monitoring on discharge (unless an appointment with EMEDSS has already been arranged within 1 week of discharge)

ATTACH AS APROPRIATE			
☐ MH assessment form	☐ Legal forms	☐ RAMP	☐ D/C Summary
☐ GP Health Summary	☐ Bloods	☐ ECG	

Once you have spoken to EMEDSS triage officer on 9224 4242, please send referral to: EMEDSSReferrals@health.wa.gov.au or fax to (08) 9224 4243

SIGNATURE:	DESIGNATION:	DATE: