

..... Clinic

NMEDSS REFERRAL FORM

Surname		Sex	UMRN
Forenames		D.O.B.	
Address			
Ward	Registrar	Consultant	
Use Patient I.D. Label when available			

Day Program
(NMEDSS accepts clients 16 - 65 years of age)

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).

Intensive Clinical Monitoring (ICM)

ICM provides medical monitoring to support other elements of treatment in the service. ICM runs five days a week. Clients can be seen 1-4 times a week for up to eight weeks.

Specialist Multidisciplinary Outpatient Clinic

Person-centred discipline specific consultations, which may include psychiatry, physician, dietetics, exercise physiology, social worker, psychology and peer support.

Date of referral:

Client's contact number:

Nominated Support Person:

Support Persons contact number:

Eating disorder diagnosis: _____

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

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: Yes No

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: _____



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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: Yes No If Yes, please attach

Self-harm – Type: _____ Safety plan: Yes No If Yes, please attach

Community Team

GP: _____ Practice: _____ Phone: _____

GP / Practice Email: _____

Community Dietitian: _____

Community Psychologist: _____

Community Psychiatrist: _____

CMHT: _____

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**