TASMANIAN HEALTH SERVICE

Tasmanian Government

TASMANIAN EATING DISORDER SERVICE REFERRAL

STATEWIDE

FACILITY: ______________________________

PT ID									

SURNAME.................................. D.O.B ....

OTHER NAMES...

ADDRESS ....

....

Attach Patient Sticker Label

(Tick ☑ as appropriate, format time as 00:00 (24 hour) and date as DD/MM/YYYY)

Complete all required information on this referral form. This will enable us to more quickly assess the care needs and priority of the referral. ALL mandatory fields are green.

Consumer Details

Referral date: DD / MM / YYYY — Consumer for referral obtained: ☐ Yes

Family name:

Given name(s):

Date of birth: DD / MM / YYYY — Pronouns:

Preferred contact details – phone number:

Email:

Interpreter/support service required: ☐ Yes ☐ No If Yes, language: ______________________ ☐ Present

If patient identifies as Aboriginal or Torres Strait Islander – Aboriginal Health Liaison Officer present: ☐ Yes ☐ No

Emergency contact *(print name)*:

Relationship to patient: — Consent to contact if required: ☐ Yes ☐ No

Phone number: — Other phone contact:

General Practitioner *(print name)*:

Practice name:

Phone number:

Reason for Referral

Service location: ☐ TEDS North-West ☐ TEDS North ☐ TEDS South

Service requested: ☐ Community Based Intensive Treatment (CBIT) ☐ Secondary consult
☐ Inpatient admission ☐ Diagnostic clarification
☐ Other *(specify)*:

Diagnosis: ☐ Anorexia nervosa ☐ Bulimia nervosa ☐ Binge eating disorder
☐ Avoidant restrictive food intake disorder ☐ Other specified feeding or eating disorder
☐ Requires clarification/unknown

Reason for referral:

Goals of referral/treatment:

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Medical Assessment

☐ I acknowledge and have reviewed the Tasmanian Health Pathways Eating Disorder Pathway for Adults, and I am aware of the indicators for psychiatric or medical admission, and this person does not require hospital admission

Medical history:

☐ Blood results less than 2 weeks old, (FBE, UEC, LFT, CMP) are attached (required)

Medications:

Anthropometry:	Weight:	*kilograms (kg)*	Date measured: DD / MM / YYYY
	Height:	*centimetres*	BMI (kg/m2):

Weight history *(include timeframe, for example 10kg loss in 2 months)*:

Observations: Blood Pressure – completed 2 minutes apart (both required)

Lying: Standing:

Heart Rate – completed 2 minutes apart (both required)

Lying: Standing:

Respiratory rate: Temperature:

Amenorrhoea: ☐ Yes ☐ No ☐ N/A

Physical complications: ☐ Fainting ☐ Dizziness ☐ Chest pain ☐ Dehydration ☐ Other *(specify)*:

Nutritional intake *(for example number of meals, food quantity, daily eating pattern, supplements)*:

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Mental Health and Eating Disorder Behaviour Assessment

Past psychiatric history: ☐ Yes ☐ No

Details if yes:

Drug and alcohol use disorder: ☐ Yes ☐ No

Details if yes:

Mental health assessment:

☐ Suicidal thoughts/intent/plan ☐ Self harm

Eating disorder behaviours: ☐ Oral restriction ☐ Vomiting ☐ Bingeing ☐ Exercise ☐ Diuretic misuse ☐ Laxative misuse ☐ Other *(specify)*:

Details *(for example frequency)*:

Psychosocial History and Current Circumstances

Details *(living arrangements, family, relationships, education, employment, financial situation)*:

Current/Previous Community Supports

Previous eating disorder treatment: ☐ Yes ☐ No

Psychiatrist: ☐ Current ☐ Previous

Details:

Psychologist: ☐ Current ☐ Previous

Details:

Dietitian: ☐ Current ☐ Previous

Details:

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Risk Factors

☐ Current suicidal thoughts/expressed intent ☐ Work at risk ☐ Harm to others

☐ Patient has plans/means to attempt suicide ☐ Alcohol and drug use ☐ Driving risk

☐ Care of children ☐ Other *(specify)*:

Additional Information

Referrer Details

Referred from:

Referrer *(print name)*: Designation:

Phone number: Other phone contact:

Signature: Date: DD / MM / YYYY

Send referral to Access Mental Health by email, and for more information phone:

South:	Email: acstriagesouth@ths.tas.gov.au	Phone: 1800 332 388	Fax: 03 6173 0306
North:	Email: acstriagenorth@ths.tas.gov.au	Phone: 1800 332 388	Fax: 03 6173 0859
North West:	Email: acstriagenorthwest@ths.tas.gov.au	Phone: 1800 332 388	Fax: 03 6464 1963

NOTE: This form should be utilised to make a referral to community based public mental health services statewide for all individuals 18 years or older. If this referral is for children under 18 years –contact Child and Adolescent Mental Health Service (CYMHS) at (03) 6166 0588 to request a CYMHS Referral form.

Email or fax the completed form to Access Mental Health (available all hours) with all relevant reports.

Send to the relevant region if possible. Clear writing and current contact details are appreciated to avoid any delay in progressing this referral. Use the pdf version and a typed form would be appreciated.

Any confidential or urgent issues can be notified by telephone **1800 332 388.**

Referral RESPONSE Priority (For office use only)

Priority	Priority meaning	Priority response
1	EMERGENCY	Refer to emergency services
2	URGENT	Commence within 2 hours
3	HIGH PRIORITY	Commence within 24 hours
4	LOWER PRIORITY	Commence within 48 hours
5	NON URGENT REFERRAL	Refer to MH team within 2 weeks
6	REFERRAL OUT/AWAIT CONTACT	Refer to appropriate organisation
7	INFORMATION ATTAINED	No further action needed

Allocated region: ☐ South ☐ North ☐ North-West

Allocated Care Coordinator:

Abbreviation key: BMI body mass index | **CMP** calcium, magnesium and phosphate | **FBE** full blood examination | **kg/m^2** kilograms per metre squared | **LFT** liver function test | **N/A** not applicable | **THS** Tasmanian Health Service | **UEC** urea, electrolytes and creatinine | **CBIT** Community Based Intensive Treatment | **TEDS** Tasmanian Eating Disorder Service | **CYMHS** Child and Youth Mental Health Services

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