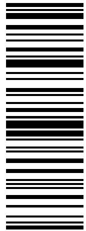
ACED Referral

U.R Number ………………………………………..
Surname ……………………………………………
Given Name(s) ……………………………………..
Date of Birth ……………………………………
AFFIX PATIENT LABEL HERE



Referral Source
Dr...
Address...
Phone............................ Fax.................................
Provider No...
Email..
Signature..
Date of Referral...

Physical Parameters
Weight........... kg Height.............cm
Temperature.............°C
Lying pulse.................. Lying BP..........................
Standing pulse............ Standing BP....................
Menstrual status..

Patient Address...
....
Home Phone..
Mobile.................................Gender........................
Medicare No...

Diagnostics – Please attach results of the following investigations:
☐ ECG ☐ FBE ☐ UEC ☐ LFTs ☐ Ca, Mg, PO4
☐ Random glucose ☐ TFTs ☐ Iron studies

Medications
....
....
....
....

Recent Weight Trajectory

Current Eating Disorder Symptoms

Physical Symptoms including Syncope

Co-morbid Mental and Physical health diagnoses

Current Risk Issues

Family Situation

Treating Team (if applicable)

Please return completed forms to the Paediatric Eating Disorder Service for triage
Fax to 03 9496 5386
Email – Paediatriceatingdisorders@austin.org.au. Telephone – 03 9496 5000 pager 5515

Adolescent & Child Eating Disorder (ACED) Referral

C1.10