



**Specialist Eating Disorder Service (SEDS)
Referral**

U.R Number
Surname
Given Name(s)
Date of Birth

AFFIX PATIENT LABEL HERE

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

Home Phone.....
Mobile..... Gender.....
Medicare No.....
Carer Name.....
Carer Phone.....
Carer Email.....

Physical Parameters

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

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

Medications

Weight Trajectory and History

Current Eating Disorder Symptoms / Behaviours

- Use of laxatives Exercise
- Binging Other
- Purging / vomiting
- Restrict

24 hour oral intake

Physical Symptoms including Syncope

Co-morbid Mental and Physical health diagnoses

Current Risk Issues

Family / Social Situation

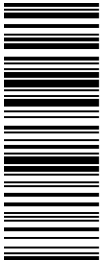
Treating Team (if applicable)

Please return completed forms to Mental Health Triage.

Fax to 03 9496 6926 Telephone – 1300 859 789

For referrals to Infant, Child, and Youth Mental Health please email –

Paediatriceatingdisorders@austin.org.au or under18triage@austin.org.au



FAH067084a

Specialist Eating Disorder Service (SEDS) Referral

C1.10a