South Metropolitan Health Service Kara Maar (Specialist Community Eating Disorders Service) **REFERRAL FORM**	SURNAME:	UMRN:
	GIVEN NAMES:	DOB:
	ABORIGINAL or TSI: ☐ Yes ☐ No	Sex: ☐ Male ☐ Female ☐ Other
	ADDRESS:	
	EMAIL:	PHONE:

Please ensure that the following information is provided in addition to this referral form:

- GP Medical Monitoring Form,
- ECG (<7 days ago), **AND;**
- Bloods
  - (Amylase, B12/Folate, FBC, Iron Studies, Prolactin, TFTs, U/E, LFT, calcium, Mg, Phosphate, LH/FSH, Estrogen, Testosterone, SHBG).

Kara Maar Eligibility Criteria:

- Age: 16 and older
- Catchment: Lives in South Metropolitan Health Service & WACHS Links Catchment - Presenting with symptoms that may indicate an eating disorder diagnosis.

DOES THE CONSUMER MEET SERVICE CRITERIA? ☐ Yes ☐ No, please specify referral reason:

DOES THE CONSUMER CONSENT TO THE REFERRAL? ☐ Yes ☐ No		**Referral Date:**
Consumer details	Preferred name:	Pronouns:
	Name:	Designation:
REFERRER (MEDICAL)	Email:	
	Phone:	
NEXT OF KIN / NOMINATED SUPPORT	Name:	Phone:
	Relation:	Address:
	For <18, Legal Guardian:	
GP (if not referrer)	Name:	Phone:
	Practice:	Fax:
	Email:	
COMMUNITY SUPPORTS	Dietitian:	Clinical Psychologist:
	Psychiatrist:	Other:
If YES, please specify:	Hospital:	Treating team / ward:
	Treating Consultant (Medical/Psych):	

EATING DISORDER ASSESSMENT

Diagnosis:

☐ Dietary restriction ☐ Vomiting ☐ Bingeing ☐ Over exercising ☐ Laxatives ☐ Diuretics / diet pills
Provide details if ticked:

ANTHROPOMETRY (date recorded:)

Height (cm):	Weight (kg):	BMI (kgm2):

Weight history:

RISK FACTORS

☐ Suicidal attempts/ thoughts / intents / plan, specify:	☐ Self harming, specify:
☐ Past history of suicide attempt/self harm	☐ Substance use (inc. alcohol and other drugs), specify:
☐ Impulsivity	Provide details if ticked and any other relevant background risk / additional information:
☐ Forensic History	

MEDICAL & MENTAL HEALTH ASSESSMENT AND HISTORY			
Observations completed date:			☐ ECG attached
BP lying	BP standing	HR lying	HR standing
Allergies/adverse drug reactions:			
Psychiatric diagnoses / history / concerns:			
Legal issues:			
Previous admissions (medical / mental health):			
Current medications:			

SOCIAL SITUATION	FAMILY SITUATION
Accommodation: Occupation: Primary Language:	Dependants: Relationships:

PLEASE NOTE, THE MEDICAL ASSESSMENT FORM MUST BE COMPLETED PRIOR TO COMMENCEMENT WITH KARA MAAR.
PLEASE ATTACH ANY RELEVANT DOCUMENTATION INC. RECENT BLOODWORK, ECG etc.

After you have spoken with the Kara Maar Triage Officer on **08 6392 1700** send this referral to SMHS.KaraMaar.Triage@health.wa.gov.au

If you have any further questions regarding this referral, please phone SMHS Kara Maar on 08 6392 1700.

BSL	RR	Temp	Amenorrhea ☐ Yes ☐ No
☐ Blood results **less than 2 weeks old** – including FBC, UEC, Mg, PO4, Ca, LFTs attached **(required)**			
Physical concerns: ☐ Fainting ☐ Dizziness ☐ Chest pain ☐ Dehydration ☐ Other, specify:			
Known disabilities or impairments:			

I acknowledge:

☐ I have read the WAEDOCS guidelines and Kara Maar GP Guide and will continue to medically monitor this consumer as per criteria.

☐ Consumer does not require immediate admission as per WAEDOCS admission guidelines.

☐ Physical Health Examination form is completed and attached.