Please use I.D. label or block print

SOUTH METROPOLITAN HEALTH SERVICE

COCKBURN HEALTH EATING DISORDERS PROGRAM

WARD _____

DOCTOR _____

SURNAME	UMRN	
GIVEN NAMES	DOB	GENDER
ADDRESS		POSTCODE
	TELEPHONE	

EMR335555

This form is to be completed in conjunction with the Cockburn Health referral form

Patient consents to referral ☐ Yes ☐ No

Patient agreeable to Cockburn Health making contact to discuss referral ☐ Yes ☐ No

Diagnosis / Eating disorder concerns _____

Mental Health and Eating Disorder Behaviour Assessment *(multiselect, include details for each selected – onset, triggers, frequency, duration etc.)*

☐ Oral restriction: _____

☐ Vomiting: _____

☐ Bingeing: _____

☐ Over-exercising: _____

☐ Diuretics / Laxatives: _____

☐ Weight Loss Medication / Stimulants / Performance Enhancing Drugs: _____

☐ Specific Food Aversions / Avoidance: _____

☐ Other: _____

Impact of eating disorder on daily life: ☐ Low ☐ Medium ☐ High

Motivation / readiness to try program / active treatment: ☐ Low ☐ Medium ☐ High

DO NOT WRITE IN MARGIN

HCHFSFOR1257

FS1257
02/26

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Medical Information

Date completed: _____

Height: _____ **cm** **Weight:** _____ **kg (date:** _____ **)** **BMI:** _____

Weight history *(attach copy of tracking if available, note history / recent changes / concerns / trends related to reason for referral):* _____

_____

_____

Postural observations: BP Lying: _____ BP Standing: _____ HR Lying: _____ HR standing: _____

BGL: _____ Time *(before / after meal)*: _____

Symptoms: _____

Physical complications:

- ☐ Amenorrhea: _____
- ☐ Dizziness / Fainting: _____
- ☐ Oedema: _____
- ☐ Chest pain: _____
- ☐ Arrhythmias: _____
- ☐ Dehydration: _____
- ☐ Other: _____

Functional Care Needs:

- ☐ Mobility: _____
- ☐ ADLs: _____
- ☐ Equipment: _____
- ☐ Cognitive Concerns: _____
- ☐ Swallowing issues / Texture modified diet: _____

Nutritional intake *(Note number of meals / estimated calories per day, recent changes in diet, other relevant details):* _____

_____

_____

_____

Attach the following:

- ☐ Blood results less than 7 days old – including LFT, UEC and FBC

Attach if available:

- ☐ Recent ECG
- ☐ Weight monitoring information
- ☐ Postural HR/BP monitoring information
- ☐ Relevant medical / dietetics / psychiatry notes (if service uses DMR not required)

Referrer: _____ Signature: _____ Date: _____

DO NOT WRITE IN MARGIN