GP Referral Admission Form

The Melbourne Clinic

General Practitioner Referral for Admission to the Eating Disorder Program

Please complete in full and return to Intake on Fax no: 9420 9351
For further enquiries please contact Intake on: 9420 9340
For further information visit: www.themelbourneclinic.com.au

Patient's contact details:	Referring Doctor:
Name:	Name:
Address:	Address:
Date of birth:	Fax no:
Phone no:	Phone no:
Gender: Male ☐ Female: ☐	Email:
Health cover:	Provider No.:
Health Insurer:	
Insurance policy no:	
Medicare no:	
Reason for referral:	
Height:	
Weight:	
BMI:	
History of rapid weight loss: Yes ☐ No ☐	
Date of onset of present complaint:	
Has the person previously seen you or another clinician in relation to this or another mental health condition? Yes ☐ No ☐ Don't know ☐	
Risk to self (including risk of self-neglect):	
Risk to others:	

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Past psychiatric history (N.B. please include copies of correspondence):

Past Medical & Surgical history:

Family/Social History:

Medications:

Bloods and E.C.G. (please enclose recent blood results and E.C.G):

History of addictions or forensics (please see overleaf for additional patient information):

Signed: Date: