Referral form Binge Eating Disorder program

The Melbourne Clinic
by Healthscope

Patient Name:	
Patient pronouns:	
Patient address:	
Date of Birth:	Phone Number:

NOK name:	
Relationship:	Phone Number:

Referring doctor:
Phone:
Email:

Diagnoses	Current treatment

Current binge eating disorder symptoms

Frequency of binge eating:

List any other eating disorder behaviours (e.g., dietary restriction, body checking/avoidance):

Confirm no compensatory behaviours (e.g., purging, driven exercise) (Y/N)

If any compensatory behaviours are present, please list type and frequency.

Binge eating disorder history

Onset of binge eating:

In your opinion, is the patient able to complete and engage in an intensive binge eating disorder inpatient program (e.g., attend and participate in all groups, complete daily food monitoring records, engage in regular eating)?

Is a parent/family member/carer willing to be involved in family sessions? If yes, please provide details.

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Past psychiatric history and management

Please indicate any relevant background information (including any previous eating disorder treatment):

Current clinical risk

Please tick appropriate response and add relevant details.

	Low	Moderate	High	Details
Suicidality				
Self-harm				
Aggression				
Cognitive Impairment				
Substance abuse				
Judgement				
Serious medical Condition				
Any other issues/ vulnerabilities				

Sign _____ **Date** _____

Referrals:

Email to TMCIntake.admin@healthscope.com.au or fax to 9420 9351

Enquiries:

The Melbourne Clinic intake team, P 9420 9340

ACCREDITED

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