Government of Western Australia
Child and Adolescent Health Service

Child & Adolescent Mental Health Service (CAMHS)
EATING DISORDER SERVICE REFERRAL FORM

STRICTLY CONFIDENTIAL

In the event of a mental health emergency
Please contact the *CAMHS Emergency Telehealth Service* on 1800 048 636
or present to your nearest Emergency Department

In the event of a physical health emergency
Please call 000 or present to your nearest Emergency Department

REFERRER'S DETAILS: (Please write or print clearly):

NAME:______________________________ROLE/POSITION: ________________

Practice/ Agency name:____________________Tel:__________Fax:__________

Address:____________________________________Post Code: ________

Have you directly assessed the child? YES ☐ NO ☐ Date of last contact with the referred person:___/___/____

Date of this Referral:___/___/____ Signature: ____________________________

CHILD / YOUNG PERSON'S DETAILS:

CHILD/ YOUNG PERSON'S SURNAME:________________NAMES:____________________

IS CHILD/ YOUNG PERSON KNOWN BY ANY OTHER NAMES:________________DOB:___/___/___.

GENDER: FEMALE ☐ MALE ☐ OTHER/NOT SPECIFIED ☐

MEDICARE NUMBER:______________ Ref:_____ Exp:_______

CURRENT ADDRESS:____

SUBURB:________________STATE:_____P/CODE_____

HOME PHONE:_____________MOBILE:_____________EMAIL:__________________

ABORIGINAL <u>AND</u> TORRES STRAIT ISLANDER (TSI) ☐ ABORIGINAL <u>NOT</u> TSI ☐ TSI <u>NOT</u> ABORIGINAL ☐

OTHER ETHNICITY ☐ ________________

INTERPRETER REQUIRED? YES ☐ NO ☐ PREFERRED LANGUAGE: ____________________

REQUESTED GENDER OF INTERPRETER: FEMALE ☐ MALE ☐

CURRENT SCHOOL:____________________________YEAR:________PHONE: ________

PARENT'S/GUARDIAN'S/CARER'S DETAILS:

Have the parents/Guardians/Carers consented to this Referral? YES ☐ NO ☐

☐ MOTHER'S NAME:______________________Work phone/mobile:____________________

Current Address if different from client:________________________Email:_______________

☐ FATHER'S NAME:______________________Work phone/mobile:____________________

Current Address if different from client:________________________Email:_______________

☐ LEGAL GUARDIAN'S NAME:________________Relationship to Child/Young Person: ____________

Current Address if different from client:________________________Phone No:_____________

☐ OTHER:____________________________Relationship to Child/Young Person: ____________

Current Address if different from client:________________________Phone No:_____________

Government of **Western Australia**
Child and Adolescent Health Service

Physical Health Form

PHYSICAL HEALTH REVIEW FORM: (Please write or print clearly):

Current Review Date:______________________________Last review date: ____________________

ORAL INTAKE:____

Food:____

Fluid:____

WEIGHT CONTROLLING BEHAVIOURS: (frequency, intensity, duration)

Dieting/fasting	
Vomiting	
Exercise *(type, intensity, duration, frequency)*	
Substance misuse (laxatives, emetics, diuretics, alcohol, other substances)	

BINGE EATING BEHAVIOUR:

Frequency of binge eating over the past 3 months (please circle)						
< once fortnight	< once week	1-5 x week	Once a day	>2 x day	5-10 x day	>10 x day

CURRENT MEDICATIONS:____

CLINICAL EXAMINATION:

Temperature:

Lying after 5 minutes: Pulse: ________________ Blood Pressure: _________________________

Standing after 1 minute: Pulse: ________________ Blood Pressure: _________________________

Weight (shoes off): _______________________ Weight change since last review: _______________________

Highest ever weight (inc. date): _______________ Lowest ever weight (inc. date): _______________________

Height (shoes off):_______________________ BMI: ____________________ Grade of PEM: _______________

Investigations: Electrolytes:________________________ ECG: ______________________

Patient menstruating? YES ☐ NO ☐ Primary/Secondary Amenorrhoea **LNMP**:_____________________

Mental Health//Safety Concerns:

Any current mental health care: YES ☐ NO ☐ Service Provider: ___________________________

Other comments/Next Review:

Signature: ____________________________________

Thank you for your referral, we will contact you shortly with the outcome.
If you wish to discuss this referral further, please contact the EDS Triage Officer on 6456 0201.