

GP DETAILS			
GP Name		Practice Name & contact details	
Provider No.			
GP preferred method/s of multidisciplinary team communication	<input type="checkbox"/> Fax <input type="checkbox"/> Phone call <input type="checkbox"/> Email <input type="checkbox"/> Other <input type="checkbox"/> Medical Objects		
PATIENT DETAILS			
First Name		Last Name	
Date of Birth		Gender	
MENTAL STATUS EXAMINATION			
Appearance		Speech	
Normal	Flat	Constricted	Normal
Immaculate	Disheveled		Pressured
Eye contact		Attention/Concentration	
Normal	Intense	Avoidant	Normal
			Distracted
			Selected
Affect		Mood	
Normal	Flat	Constricted	Euthymic
Liable	Incongruent		Irritable
			Euphoric
			Anxious
			Dysphoric
			Other
Thought		Motor activity	
Normal	Flight of ideas	Accelerated	Normal
Retarded	Impoverished	Other	Hyperactive
			Retardation
			Tics
Memory		Attitude	
Short term intact	Short term impaired	Cooperative	Evasive
Long term intact	Long term impaired	Defensive	Guarded
			Hostile
			Withdrawn
Insight		Orientation	
Good	Poor	Time	Person
Fair	Denial of problem		Place
Judgement		Sleep	
Good	Fair	Poor	

PATIENT TREATMENT GOALS	
PRESENTING CONCERNS	GOALS
Abnormal eating pattern <input type="checkbox"/> Restriction Purging <input type="checkbox"/> Binge eating Chew & spit	<input type="checkbox"/> Establishment of regular eating behaviour
Deviation from typical body weight <input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight fluctuations	<input type="checkbox"/> Restoration of healthy body weight
Physiological complications of eating disorder <input type="checkbox"/> Malnutrition Cardiac GIT <input type="checkbox"/> Electrolyte abnormalities Amenorrhea	<input type="checkbox"/> Reversal of same
Maladaptive compensatory behaviours <input type="checkbox"/> Vomiting Laxative abuse <input type="checkbox"/> Stimulant abuse Over-exercise <input type="checkbox"/> Diuretic abuse	<input type="checkbox"/> Supported cessation of same
Exercise <input type="checkbox"/> Driven, compulsive, or excessive exercise (detail)	<input type="checkbox"/> Development of healthy relationship with exercise
Body image <input type="checkbox"/> Disturbance in the way body is viewed or experienced	<input type="checkbox"/> Address body image concerns
Psychosocial <input type="checkbox"/> Negative impact on relationships <input type="checkbox"/> Negative impact on work/study <input type="checkbox"/> Other	<input type="checkbox"/> Reclaim losses, build a fulfilling & balanced life
Relapse <input type="checkbox"/> Risk of future relapse	<input type="checkbox"/> Relapse prevention

EATING DISORDERS PATIENT PHYSICAL ASSESSMENT			
ASSESSMENT	FINDINGS	MODERATE ALERT MONITOR WEEKLY	HIGH ALERT MEETS ADMISSION CRITERIA
BMI		BMI <16	BMI <13
Weight loss		Weight loss > 0.5kg for several weeks	Weight loss 1kg or more for several weeks
Blood Pressure		Systolic – 90mmHg Diastolic - 60mmHg	Systolic – 80mmHg Diastolic - 50mmHg

			OR Postural Drop >10mmHg
Heart Rate		<50bpm	<40bpm
			OR Postural Tachycardia >20bpm increase
Temperature		<36° C	<35.5° C OR cold/blue extremities
Fluid and electrolyte changes		Phosphate – 0.5-0.9mmol/L Potassium – <3.5mmol/L Sodium – <130mmol/L	Phosphate – <0.7mmol/L Potassium – <3.0mmol/L Sodium – <125mmol/L
Liver enzymes		AST – >40	AST – >100
		ALT – >45	ALT – >100
Nutrition		Albumin – <35g/L	Albumin – <30g/L
		Glucose – <3.5mmol/L	
Cardiovascular – ECG		<50	<40 OR Prolonged QT Interval >450msec OR Arrythmias
eGFR			<60ml/min/1.73m ² OR rapidly dropping (25% within a week)
Bone Marrow		Neutrophils <1.2 x 10 ⁹ /L	Neutrophils <1.5 x 10 ⁹ /L
Physical Observations		Swollen ankles Pitting oedema Significant bruising	

GP REFERRAL REQUIREMENTS

Suicide risk performed	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Physical examination conducted	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Patient education given	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Copy of EDMP given to patient	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Copy of EDMP given to other providers	<input type="checkbox"/> YES	<input type="checkbox"/> NO

RECORD OF PATIENT CONSENT

I, _____, (patient name - please print clearly) agree to information about my mental and medical health to be shared between the GP and the health professionals to whom I am referred, to assist in the management of my health care.

Signature (patient):

Date:

I (GP) have discussed the proposed referral(s) with the patient and am satisfied that the patient understands the proposed uses and disclosures and has provided their informed consent to these.

GP Signature

GP Name

Date

GP REVIEW REQUIREMENTS

- Mental health: Prior to or at sessions 10, 20 & 30 of psychological treatment & at EDMP completion
- Dietetics: After Session 1 or 2 and at EDMP completion

Note: PSYCHIATRIC OR PAEDIATRIC REVIEW

Required in addition to GP review to access sessions 21-40. Consider referring early in course of treatment

*Assessment by psychiatrist/ paediatrician required for patient to access EMPT psychological sessions 21-40

^Psychological treatments allowed under EDMP (to be determined by MH professional):

- Family based treatment
- Adolescent focused therapy
- CBT
- CBT-AN
- CBT- BN/BED
- SSCM for AN
- MANTRA for AN
- IPT for BN or BED
- DBT for BN or BED
- Focal psychodynamic therapy for EDs