To:

Address:

Date:

Dear

RE: DOB:

Please find below an Eating Disorder Care Plan (EDP) prepared for this patient with details of their condition. This referral covers sessions 1-10 for psychological intervention, 1-20 for a dietitian, after which I will review and provide ongoing referrals as appropriate. Many thanks for your care and for your ongoing collaboration and communication.

Yours sincerely,

Name:

Date:

GP EATING DISORDER PLAN (EDP)

Item No : 90250 – 90257 MBS Quick reference

GP DETAILS			
GP Name Provider No.		Practice Name & Address	
Practice Phone		Practice Fax	
GP Health Identifier			
GP Email			

PATIENT DETAILS			
First Name (as on Medicare)		Last Name	
Preferred Name		Marital Status	
Date of Birth		Age	
Gender Identity	As identified in software: Current identity ☐ Male ☐ Female ☐ Non-binary/Gender fluid ☐ Different identity		
Address			
Phone (h)		Phone (m)	
Cultural Identity		Aboriginal or Torres Strait Islander	☐ Yes ☐ No
First Language	Interpreter needed? ☐ Yes		
Family/ Support Person Details (Consider involving support person in session if appropriate) InsideOut resources for carers Butterfly resources for carers NEDC resources for carers	Name: Relationship to patient: Pt consent to contact given ☐ Yes ☐ No Ph: ☐ Very well supported ☐ Well supported ☐ Somewhat supported ☐ Not supported Any information not to be shared with support person:		
Relevant Current Medications			

ESTABLISH ACCESS TO EDP (If not appropriate consider using a MHCP or GPMP)	
Eating Disorder Diagnosis (DSM-V) InsideOut GP HUB & diagnostic guides	☐ Anorexia Nervosa (AN) *(Criteria met for EDP)* ☐ Bulimia Nervosa (BN) *(Other criteria needed, see below)* ☐ Binge Eating Disorder (BED) *(Other criteria needed, see below)* ☐ Other Specified Eating or Feeding Disorder (OSFED) *(Other criteria needed, see below)*
EDE-Q Global Score InsideOut - EDE-Q online with scoring	EDE-Q Score: (greater than or equal to 3 to access EDP for BN, BED or OSFED)
Eating Disorder Behaviours (At least one needed to access EDP and rebates for BN, BED or OSFED)	**Eating disorder behaviours:** ☐ Rapid weight loss ☐ Binge eating (frequency >=3 times per week) ☐ Compensatory Behaviour (frequency >=3 times per week) Type of compensatory behaviours (if relevant): ☐ Purging ☐ Excessive exercise ☐ Laxative abuse ☐ Restriction/Fasting ☐ N/A Frequency of behaviour: ☐ N/A ☐ Daily ☐ Weekly ☐ Monthly
Clinical Indicators (At least 2 to access EDP and rebates for BN, BED or OSFED)	Clinical Indicators: ☐ Clinically underweight (less than 85% expected weight with weight loss due to an ED) ☐ Current or high risk of medical complications due to ED ☐ Serious comorbid psychological/medical conditions impacting function ☐ Hospital admission for an ED in past 12mths ☐ Suboptimal response to evidence based treatment over past 6mths ☐ N/A
Access to EDP Established	☐ Yes ☐ No (consider Better Access to Mental Health Plans)

MENTAL HEALTH ASSESSMENT & HISTORY	
Previous Specialist Mental Health Care	
Social & Family History	
Personal History Childhood, education, relationship history, previous stressors, protective factors	
Results of Mental State Examination Detail findings Mental state examination	Appearance: General behaviour: Speech: Mood: Affect: Thought: Perceptions: Cognition: Insight:

Risk Assessment Note any identified risks Blackdog Institute resources	Identified risk: ☐ Suicidal ideation ☐ Suicidal intent ☐ Current plan ☐ Medical risk ☐ None ☐ Other
	Plan for managing risk: ☐ Mental Health Line ☐ After hours GP service ☐ Family monitoring ☐ GP monitoring ☐ Other

MEDICAL REVIEW

Examination As indicated	Physical examination done: ☐ N/A ☐ Height, weight, BMI (adults) BMI percentile (children) ☐ Pulse & blood pressure, with postural measurements ☐ Temperature ☐ Assessment of breathing & breath (e.g. ketosis) ☐ Examination of periphery for circulation and oedema ☐ Assessment of skin colour (e.g. anaemia, hypercarotenaemia, cyanosis) ☐ Hydration state (e.g. moisture of mucosal membranes, tissue turgor) ☐ Examination of head & neck (e.g. parotid swelling, dental enamel erosion, gingivitis, conjunctival injection) ☐ Examination of skin, hair & nails (e.g. dry skin, brittle nails, lanugo, dorsal finger callouses (Russell's sign) ☐ Sit up or squat test (i.e. test of muscle power) Investigations done: ☐ FBC ☐ EUC/LFT/CMP/BSL ☐ Urinalysis ☐ Electrocardiography ☐ Iron studies, B12, folate ☐ E/P, LH/FSH, if appropriate TSH/Prl ☐ Bone densitometry – relevant after 9-12mths of disease or of amenorrhoea & as baseline in adolescents (recommendation is for 2yrly scans thereafter while DEXA scans are abnormal)
Observations	
Psychological / medical comorbidities	
Medical complications	
Protective factors	
Emergency care / relapse prevention	

INITIAL TREATMENT RECOMMENDATIONS UNDER EDP

Psychological treatment services (EDPT) (Initial 10 sessions)	Dietetic services (up to 20 in 12 months)	Psychiatric/paediatric review Assessment by psychiatrist/ paediatrician required for patient to access EDPT sessions 21-40
Referred to: Phone: Goals:	Referred to: Phone: Goals:	Referred to: Phone:
		Other team member Profession:
Psychological treatments allowed under EDP (to be determined together with MH professional): • Family based treatment, Adolescent focused therapy, CBT, CBT-AN, CBT-E, SSCM for AN, MANTRA for AN, IPT for BN or BED, DBT for BN or BED, Focal psychodynamic therapy for EDs	Dietitian to provide letter of treatment to GP at EDP completion InsideOut treatment services database	Name: Phone:

Actions for patient to take: ☐ Use of the Healthy Mind Platter ☐ Read through RAVES approach

☐ Build my treatment team ☐ Engage family/Friends ☐ Limit my exercise to set amount

☐ Attend all appointments with dietitian/psychologist ☐ Use Plate by Plate

Other actions identified by patient:

Patient education given ☐ Yes ☐ No Specify:

Copy of EDP offered to patient ☐ Yes ☐ No

GP management - frequency of review ☐ Weekly ☐ Monthly ☐ As indicated

GP REVIEW REQUIREMENTS

Mental health: Prior or at sessions 10, 20 & 30 of psychological treatment & at EDP completion

Dietetics: At EDP completion

Note: PSYCHIATRIC OR PAEDIATRIC REVIEW
Required in addition to GP review to access sessions 21-40. Consider referring early in course of treatment.

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, either via correspondence, verbal communication, or case conferences 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