To:					
Date:					
Dear					
	D0D				
RE:	DOB:				
Please find below an Eating Disorder Care Plan (EDP) prepared for this patient with details of their condition. This referral cover 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:					
2 4.6.					
GP EATING DISORDER PLAN (EDP) Item No: 90250 – 90257					
GP DETAILS					
GP Name		Practice Name &			
Provider No.		address			
Practice phone		Practice fax			
GP Health Identifier		1140400147			
GP Email					
Of 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)	Preferred support person: Ph: Pt consent to contact given □ Yes □ No				
InsideOut resources for carers	Relationship to patient: ☐ Very well supported ☐ Well supported ☐ Somewhat supported ☐ Not supported				
Butterfly resources for carers NEDC resources for carers	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	☐ Anorexia Nervosa (AN) (Meets criteria for EDP)		
Diagnosis (DSM-V)	☐ Bulimia Nervosa (BN) (Other criteria needed, see below)		
InsideOut GP Hub –	☐ Binge Eating Disorder (BED) (Other criteria needed, see below)		
diagnostic guidelines	☐ Other Specified Eating or Feeding Disorder (OSFED)(Other criteria needed)		
EDE-Q Global Score	EDE-Q Score (greater than or equal to 3 to access EDP for BN, BED or OSFED)		
InsideOut - EDE-Q online with scoring			
	Eating disorder behaviours:		
F // D)	☐ Rapid weight loss ☐ Binge eating (frequency >=3 times per week)		
Eating Disorder Behaviours	☐ Compensatory Behaviour (frequency >=3 times per week) ☐ N/A (For AN)		
Deriaviours	+Compensatory behaviours:		
(At least one needed to access EDP and rebates	☐ Purging ☐ Excessive exercise ☐ Laxative abuse ☐ N/A		
for BN, BED or OSFED)	Frequency of behaviour:		
	□ N/A □ Daily □ Weekly □ Monthly		
	Clinical Indicators:		
	☐ Clinically underweight (less than 85% expected weight with weight loss due to an ED)		
Clinical Indicators	☐ Current or high risk of medical complications due to ED		
(at least 2 to access	☐ Serious comorbid psychological/medical conditions impacting function		
(at least 2 to access EDP and rebates for BN,	☐ Hospital admission for an ED in past 12mths		
BED or OSFED)	☐ Suboptimal response to evidence-based treatment over past 6mths		
	□ N/A (For AN) Add detail as appropriate:		
Access To EDP Established	☐ Yes ☐ No (consider Better Access to Mental Health Plans)		
Established	☐ Yes ☐ No (consider Better Access to Mental Health Plans)		
	☐ Yes ☐ No (consider Better Access to Mental Health Plans)		
Established MENTAL HEALTH ASSESS	☐ Yes ☐ No (consider Better Access to Mental Health Plans)		
Established	☐ Yes ☐ No (consider Better Access to Mental Health Plans)		
MENTAL HEALTH ASSESS Previous Specialist	☐ Yes ☐ No (consider Better Access to Mental Health Plans)		
MENTAL HEALTH ASSESS Previous Specialist Mental Health Care	☐ Yes ☐ No (consider Better Access to Mental Health Plans)		
MENTAL HEALTH ASSESS Previous Specialist	☐ Yes ☐ No (consider Better Access to Mental Health Plans)		
MENTAL HEALTH ASSESS Previous Specialist Mental Health Care Social & Family History	☐ Yes ☐ No (consider Better Access to Mental Health Plans)		
MENTAL HEALTH ASSESS Previous Specialist Mental Health Care Social & Family History Personal History	☐ Yes ☐ No (consider Better Access to Mental Health Plans)		
Previous Specialist Mental Health Care Social & Family History Personal History Childhood, education,	☐ Yes ☐ No (consider Better Access to Mental Health Plans)		
Previous Specialist Mental Health Care Social & Family History Personal History Childhood, education, relationship history, previous stressors,	☐ Yes ☐ No (consider Better Access to Mental Health Plans)		
Previous Specialist Mental Health Care Social & Family History Personal History Childhood, education, relationship history,	Yes No (consider Better Access to Mental Health Plans) MENT & HISTORY		
Previous Specialist Mental Health Care Social & Family History Personal History Childhood, education, relationship history, previous stressors,	Yes No (consider Better Access to Mental Health Plans) MENT & HISTORY Appearance:		
MENTAL HEALTH ASSESS Previous Specialist Mental Health Care Social & Family History Personal History Childhood, education, relationship history, previous stressors, protective factors Results of Mental	Yes No (consider Better Access to Mental Health Plans) MENT & HISTORY Appearance: General behaviour:		
MENTAL HEALTH ASSESS Previous Specialist Mental Health Care Social & Family History Personal History Childhood, education, relationship history, previous stressors, protective factors	Appearance: General behaviour: Speech:		
MENTAL HEALTH ASSESS Previous Specialist Mental Health Care Social & Family History Personal History Childhood, education, relationship history, previous stressors, protective factors Results of Mental State Examination	Appearance: General behaviour: Speech: Mood:		
MENTAL HEALTH ASSESS 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	Appearance: General behaviour: Speech: Mood: Affect:		
MENTAL HEALTH ASSESS 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 Royal Children's Hospital	Appearance: General behaviour: Speech: Mood: Affect: Thought:		
MENTAL HEALTH ASSESS 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	Appearance: General behaviour: Speech: Mood: Affect:		



Insight:



Identified risk Suicidal ideation Suicidal intent Current plan				
Examination As indicated N/A	Note any identified risks, including risks of self-harm Black Dog Institute		□ Suicidal ideation □ Suicidal intent □ Current plan □ Risk to others □ Medical risk □ None Other: Plan for managing risk □ Mental Health Line □ After hours GP service □ Family monitoring □ GP monitoring	
Examination As indicated N/A	MEDICAL DEVIS	34/		
As indicated 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 and 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 Inon studies, B12, folate E/P, LH/FSH, if appropriate TSH/Prl Bone densitometry — relevant after 9-12mths of disease or of amenorrhoea & as a baseline in adolescents. (Recommendation is for 2yrly scans thereafter while DEXA scans are abnormal) Observations: Medical complications: Psychological/ medical comorbidities:		1	al examination done:	
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 and 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	LXamination	rilysic	ai examination done.	
Psychological/ medical comorbidities:		□ 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 and 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 a baseline in adolescents. (Recommendation is for 2yrly scans thereafter while DEXA scans are abnormal)		
Psychological/ medical comorbidities:	Medical compli	ications:		
	Psychological/	medical	comorbidities:	



Emergency care/relapse prevention:



INITIAL TREATMENT RECOMMENDATIONS UNDER EDP					
Psychological treatment services	Dietetic services	Psychiatric/paediatric review			
(EDPT) (Initial 10 sessions)	(up to 20 in 12 months)	Accessment by psychiatriat/			
		Assessment by psychiatrist/ paediatrician required for patient to			
	Dietitian to provide letter of treatment to GP on completion	access EDPT sessions 21-40			
	Gr on completion				
Referred to:	Referred to:	Referred to:			
Phone:	Phone:	Phone:			
		Priorie.			
Goals:	Goals:				
Psychological treatments allowed under EDP		Other team member			
(to be determined together with MH		Profession:			
professional):		Name:			
Family based treatment, Adolescent		Phone:			
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	InsideOut Treatment Services Database				
. 3					
GP management – frequency of review	2 W				
☐ Weekly ☐ Monthly ☐ As indicated	ated				
Actions for patient to take: ☐ Use of	of the Healthy Mind Platter Read	d through RAVES Approach			
□ Build my treatment team □ Enga		my exercise to set amount			
☐ Attend all appointments with dietit	•	Plate by Plate			
Attend all appointments with dietit	lari/psychologist — — Ose	Tate by Flate			
Other actions identified by patient:					
Patient education given	No Specify:				
Copy of EDP offered to patient	es □ No				
OR DELIVERY DECLUDED AFRICA					
GP REVIEW REQUIREMENTS Montal health: Prior or at appaigns 10) 20 9 20 of payabalagical treatme	nt 8 at EDD completion			
Mental health: Prior or at sessions 10	o, 20 & 50 of psychological treatme	nt & at EDP Completion			
Dietetics: At EDP completion	DEV. (15) A /				
Note: PSYCHIATRIC OR PAEDIATRIC REVIEW					
Required in addition to GP review to access sessions 21-40. Consider referring early in course of treatment.					
DECORD OF DATIENT CONSENT					
RECORD OF PATIENT CONSENT	(noticet name places print also	rh ()			
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.					
The state of the s					
Signature (patient):	Date:				
= 2					
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.					
CD Cignotus	CD Name	Dat-			
GP Signature	GP Name	Date			



