To:

Date:

Dear

RE: DOB:

Please find below an Eating Disorder Care Plan Review prepared for this patient with details of their condition. This referral covers sessions Many thanks for your continuing care and for your ongoing collaboration and communication.
Yours sincerely,

Dr Name:

Date:

GP EATING DISORDER REVIEW (EDR)

Item No : 90264 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 (if different): ☐ 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	Preferred support person: Ph: Pt consent to contact given ☐ Yes ☐ No Relationship to patient: ☐ Very well supported ☐ Well supported ☐ Somewhat supported ☐ Not supported Any information not to be shared with support person:
Relevant Current Medications	

GP REVIEW

GP Review Time Point:	☐ After session 10 ☐ After session 20 ☐ After session 30
Eating Disorder Behaviours InsideOut GP HUB Management supports	**Continuing behaviours:** ☐ Restriction ☐ Weight loss ☐ Body image concerns ☐ Binge eating ☐ Rumination ☐ Pica ☐ Other Specify: Behaviour frequency: ☐ Daily ☐ Weekly ☐ Monthly **Restriction type (If relevant):** ☐ Skipping meals ☐ Fasting ☐ Fad diets ☐ Avoiding food groups ☐ Other Specify: **Compensatory behaviours (If relevant):** ☐ Purging ☐ Excessive exercise ☐ Laxative abuse ☐ Other Specify: Behaviour frequency: ☐ Daily ☐ Weekly ☐ Monthly
Risk Assessment Note any identified risks, including risks of self-harm Black Dog Resources	**Identified risk:** ☐ Suicidal ideation ☐ Suicidal intent ☐ Current plan ☐ Medical risk ☐ None ☐ Other Specify:
Risk Management	**Plan for managing risk:** ☐ Mental Health Line ☐ After Hours GP service ☐ Family monitoring ☐ GP monitoring ☐ Other Specify:
Observations	

REVIEW TREATMENT RECOMMENDATIONS UNDER EDP

Psychological treatment services (EDPT)	Dietetic services (up to 20 in 12 months) Dietitian to provide letter of treatment to GP on completion	Psychiatric/paediatric review Assessment by psychiatrist/ paediatrician required for patient to access EDPT sessions 21-40
Referred to: Phone: Progress review/comments: InsideOut Treatment Services Database	Referred to: Phone: Progress review/comments:	Referred to: Phone: Comments: ** For review at session 20 only: Does specialist review (psychiatry/ paediatrics) support additional sessions 21-40? ☐ Yes ☐ No Specialist letter attached? ☐ Yes ☐ No

Emergency Care/Relapse Prevention:

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 for GP to take:

GP management – frequency of review/monitoring ☐ Weekly ☐ Monthly ☐ As indicated

Additional 10 EDPT sessions recommended	☐ Yes ☐ No
Copy of EDP Review offered to patient	☐ Yes ☐ No
Physical examination conducted	☐ Yes ☐ No

EATING DISORDERS PATIENT PHYSICAL ASSESSMENT

Suggested minimum physical assessment	Height, weight, body mass index (BMI; adults), BMI percentile for age (children) pulse and blood pressure, with postural measurements, temperature
Any significant findings / comments	

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