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|  | | | | | |  | | **Youth Eating Disorders (16 + 17 years) Referral & Consent Form** | | | | | | | | | | | | | |
| Patient Details | | | | | | | | | | | | | | | | | | | | |
| **Name**: |  | | | | | | | | | | | | | | | **Sex:** | | |  | **Identified Gender:** |
| **DOB**: | |  | | | | | | | | **Medicare** No: | | | Exp: | | | | | | | |
| **Address**: | | | |  | | | | | | | | | | | | | | | | |
| **Phone** No: | | | |  | | | | | | | | **Mobile** No: | | | | | |  | | |
| **Country of birth**: | | | | |  | | | | | | | | | **Email**: | | | |  | | |
| **Primary caregiver 1:** | | | | | | |  | | | | | | | | | | | Relationship: | | |
|  | | | **Mobile** No : | | | | | | | | | | | | | |  | **Email**: | | |
| **Primary caregiver 2**: | | | | | | |  | | | | **Mobile** No: | | | |  | | | | | **Email**: |
| **Resides with** (please list): | | | | | | | | |  | | | | | | | | | | | |

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| **Treatment Programs** (✓ or 🗶 the program you are referring for)  **NOTE: Suitability for treatment is determined via a detailed assessment with the young person and their primary caregivers** |

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| **Family-based treatment (FBT)**: 16 + 17 year olds will always be assessed for suitability for the FBT program  **Individual Treatment**: please indicate why the young person may not be suitable for family-based treatment  **NOTE:**   * **CCI does *not* treat ARFID or Binge Eating Disorder.** * Referrals to Eating Disorders program **must be from a medical practitioner who provides *ongoing* medical management.** | **Patients must have a BMI > 16**  Height:      cm, Weight:      kg  **Please 🗸 relevant current symptoms**  Restricted eating  Binge eating  Vomiting  Laxative use  Unhealthy exercise  Rapid weight loss  *Note:* Patients must have a minimum Body Mass Index of 16. |

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| Referral InformationNB: *Please check the inclusion & exclusion criteria for CCI referrals* | |
| Primary Diagnosis: |  |
| Reason for Referral: | |

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| Current Risk Factors:  (Please note any details as relevant) |  | Current Medications and Dosage:  (You may wish to attach a printed medication profile) |
| Suicide risk |  |  |
| Deliberate self-harm |  |  |
| Alcohol misuse |  |  |
| Drug misuse |  |  |
| Forensic history / history of aggression |  |  |
| *Notes/Other*: | *CCI offers weekly, outpatient treatment sessions. If risk factors are present, please consider whether these can be appropriately managed in this setting.* |  |
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|  |  | *Please* ***complete referral*** *overleaf…* |

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| **Patient Consent:**  *This referral has been discussed with me, and* ***I am aware of the following:*** |
| All appointments at CCI are during normal business hours (9am-5pm, Monday to Friday). |
| There is a waiting list for treatment at CCI. |
| CCI offers a limited number of focused weekly sessions.  My parents/primary caregivers may be included in my assessment and treatment at CCI and will   be made aware of my referral to CCI. |
| **Patient signature**: Date: |

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| **Referral Source:**   * Referrals to the Eating Disorders program **must be from a medical practitioner** (e.g., GP, Psychiatrist) **who can provide ongoing medical monitoring of the patient for the duration of treatment** | | |
| Referrer’s Name: | | |
| Position (eg. GP, Psychiatrist): | | |
| Service: | | |
| Address: | | |
| Email:       **Referrer’s signature**: | | |
| Referral date:      /     / | Phone No: | Fax No: |

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| **Please List Any Other Services The Young Person Is Engaged With:** | | | | | |
| Name: |  | Position: |  | Organisation: |  |
| Name: |  | Position: |  | Organisation: |  |
| Name: |  | Position: |  | Organisation: |  |

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| **Please send all referrals to** the Clinic Manager at CCI, 223 James Street, Northbridge WA 6003, **or fax to** (08) 9328 5911, or scan and email to [info.cci@health.wa.gov.au](mailto:info.cci@health.wa.gov.au). Please call on (08) 9227 4399 if you have any enquiries or if you wish to discuss your patient’s needs. |

*Please consider the following:*

# Inclusion Criteria:

* CCI is a state-wide service and can accept referrals from all regions within Western Australia
* Patient must be over 16 years of age for the Eating Disorders Program
* Patients must have a current Medicare card
* Patients must have a clearly defined primary diagnosis in one of the following areas:
* Anorexia Nervosa & Atypical Anorexia Nervosa
* Bulimia Nervosa & Atypical Bulimia Nervosa

# Exclusion Criteria: Referral to CCI is not appropriate for patients who:

* have a Body Mass Index < 16 (an inpatient admission may be required)
* are medically unstable
* misuse alcohol or other drugs (a referral to Next Step may be more suitable)
* have a concurrent diagnosis in the psychotic spectrum
* are concurrently receiving treatment as an in-patient in a psychiatric hospital
* current aggression / problems controlling anger

***Thank you for your referral***

*CCI is an outpatient, state-wide mental health service offering free,   
evidence-based treatment for eating disorders.*

**CCI’s Youth Eating Disorders** (16 + 17 years) **Referral & Consent Form**