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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | |  | | **Referral & Consent Form** | | | | | |
| Patient Details | | | | | | | | | | | | | |
| **Name**: |  | | | | | | | | | | **Sex:** | **M**  **F** | **Identified Gender:** |
| **DOB**: | |  | | | | | **Medicare** No: | | | Exp: | | | |
| **Address**: | | |  | | | | | | | | | | |
| **Phone** No: | | | |  | | | | | **Mobile** No: | |  | | |
| **Country of birth**: | | | | |  | | | | **Email**: | |  | | |

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| **Treatment Programs**  **16-18 year olds** may be referred to **Eating Disorder** program***only,*** please seeCCI’s **Youth Eating Disorder** Referral Form. |

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| ✓ or 🗶 the program you are referring for:  **Bipolar Course** (adjunctive to psychiatric management)  **Mood Management** **Course** (Depression/Anxiety)  **Panic Disorder Course**  **Social Anxiety Course**  **Worry and Rumination Course**  **Individual Treatment** | **Eating Disorders Group Treatment**  **Eating Disorders Individual Treatment**  **Patients must have a BMI > 16**  Height:      cm, Weight:      kg  **Please 🗸 *current* symptoms**  Restricted eating  Binge eating  Vomiting  Laxative use  Unhealthy exercise  Rapid weight loss  **NOTE:**Referrals to Eating Disorders program *must be* **from a medical practitioner who provides *ongoing* medical management.** |
| **NOTE**: CCI follows a stepped care approach. **Group treatment** is usually the first option considered. | |

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| Referral Information: *Please check the inclusion & exclusion criteria on page 2* | |
| 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 |  |  |
| *CCI offers weekly, outpatient treatment sessions.* ***If* any of the above risk factors are present, *please consider whether these can be appropriately managed in this setting.*** |  | *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-4:30pm, Monday to Friday). |
| There is a waiting list for treatment at CCI. |
| CCI offers a limited number of focused weekly sessions. |
| **Patient signature**: Date: |

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| **Referral Source**: | | | |
| Referrer’s Name:       Position (eg. GP, Psychiatrist): | | | |
| Service: | | | |
| Address: | | | |
| Email: | | | |
| Referral date:      /     / | Phone No: | | Fax No: |
| * CCI is a tertiary service offering short-term treatments. We require a relevant point of contact for when patients are discharged from our service. ***If* you will *not have ongoing involvement* in the patient’s care**, please *provide a supporting referral from a relevant medical practitioner.* | | | |
| **Referrer’s signature:** | |  | |

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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
* Patients must be over 18 years of age (or 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
* Avoidant Restrictive Food Intake Disorder
* Binge Eating Disorder
* Bipolar Disorder (adjunctive to psychiatric management)
* Body Dysmorphic Disorder
* Bulimia Nervosa & Atypical Bulimia Nervosa
* Generalised Anxiety Disorder
* Health Anxiety
* Major Depressive Disorder
* Panic Disorder/ Agoraphobia
* Social Anxiety Disorder

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

* Have a Body Mass Index < 16 (an inpatient admission may be required)
* 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***