Queensland Government

Royal Brisbane & Women's Hospital

QUEENSLAND EATING DISORDER SERVICE (QuEDS) REFERRAL FORM

URN:

Family Name:

Given Names:

Address:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Referral for:

☐ Specialist Consultation Clinic (Public Assessment Clinic)

☐ Dr Warren Ward - Private Bulk Billing Clinic (**Assessment Clinic**)

☐ Dr Chris Randall Private Bulk Billing Clinic (**Day Program**)

☐ Patient does not require immediate admission as per QuEDS admission guidelines

☐ I have read the QuEDS guidelines and will continue to medically monitor this patient as per pg 2 criteria

Client Details and Demographics:

Home phone no: Work phone no: Mobile no:

Marital status: Medicare no: Expiry:

Country of birth: Year of arrival: Indigenous status:

Occupation or benefit / pension:

Employment status: Education level:

Name - Next of kin or significant other: Phone no:

Relationship to patient: Address:

Patient has consented to next of kin contact if required: ☐ Yes ☐ No

Diagnosis & reason for referral:

Initial Risk Assessment

☐ Suicidal thoughts / intent / plan ☐ Self-harming Type: ☐ Access to weapons

Height: m Weight: kg BMI:

☐ Rapid weight loss How much? Timeframe:

Physical complications: ☐ Fainting ☐ Dizziness ☐ Chest pain ☐ Dehydration ☐ Other

Medical Assessment

BP - Lying: Standing: PR - Lying: Standing:

RR: Temp: Amenorrhea: ☐ Yes ☐ No

Bloods taken (FBC, U & E) date: N.B. Blood results <2 weeks old **must be included** with referral form (FBC, ELFT, Mg and Phosphate).

Please note: incomplete forms or not attaching blood results will delay triage.

Medical history & medications:

Eating D/O Behaviours: *e.g. frequency, severity etc.*

☐ Oral restriction ☐ Vomiting ☐ Bingeing ☐ Exercise ☐ Diuretic ☐ Laxatives

Past Psychiatric History: ☐ Yes ☐ No Drug & Alcohol Issues: ☐ Yes ☐ No

If "Yes" to either question, provide details below:

Is patient aware of referral: ☐ Yes ☐ No Does patient agree? ☐ Yes ☐ No

Referrer's name: Designation:

Contact email: Phone No:

GP's name (**required** if not referrer): Contact No:

GP or practice email:

Referring doctor signature: Provider No: Date:

Send to Queensland Eating Disorders Service (QuEDS) by: Fax - 3100 7555 or email QuEDS@health.qld.gov.au
For more information please google "QuEDS" or phone - 3114 0809

QUEENSLAND EATING DISORDER SERVICE REFERRAL FORM

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