

South Metropolitan Health Service Kara Maar (Specialist Community Eating Disorders Service) REFERRAL FORM	SURNAME:		UMRN:	
	GIVEN NAMES:		DOB:	
	ABORIGINAL or TSI: <input type="checkbox"/> Yes <input type="checkbox"/> No		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
	ADDRESS:			
	EMAIL:		PHONE:	
Kara Maar Eligibility Criteria: <ul style="list-style-type: none"> - Age: 16 and older - Catchment: Lives in South Metropolitan Health Service & WACHS Links Catchment - Presenting with symptoms that may indicate an eating disorder diagnosis. DOES THE CONSUMER MEET SERVICE CRITERIA? <input type="checkbox"/> Yes <input type="checkbox"/> No, please specify referral reason:				
DOES THE CONSUMER CONSENT TO THE REFERRAL? <input type="checkbox"/> Yes <input type="checkbox"/> No				
CONSUMER DETAILS		Preferred name:		Pronouns:
REFERRER (Medical)	Name:		Designation:	
	Email:			
	Phone:			
NEXT OF KIN / NOMINATED SUPPORT	Name:		Phone:	
	Relation:		Address:	
	For <18, Legal Guardian:			
GP (if not referrer)	Name:		Phone:	
	Practice:		Fax:	
	Email:			
COMMUNITY SUPPORTS	Dietitian:		Clinical Psychologist:	
	Psychiatrist:		Other:	
	Hospital:		Treating team / ward:	
	Treating Consultant (Medical/Psych):			
EATING DISORDER ASSESSMENT				
Diagnosis:				
<input type="checkbox"/> Dietary restriction <input type="checkbox"/> Vomiting <input type="checkbox"/> Bingeing <input type="checkbox"/> Over exercising <input type="checkbox"/> Laxatives <input type="checkbox"/> Diuretics / diet pills Provide details if ticked:				
ANTHROPOMETRY (date recorded: _____)				
Height (cm):		Weight (kg):		BMI (kgm2):
Weight history:				
RISK FACTORS				
<input type="checkbox"/> Suicidal attempts / thoughts / intents / plan, specify:		<input type="checkbox"/> Self harming, specify:		
<input type="checkbox"/> Past history of suicide attempt / self harm		<input type="checkbox"/> Substance use (inc. alcohol and other drugs), specify:		
<input type="checkbox"/> Impulsivity		Provide details if ticked and any other relevant background risk / additional information:		
<input type="checkbox"/> Forensic history				
MEDICAL & MENTAL HEALTH ASSESSMENT AND HISTORY				
Observations completed date:			<input type="checkbox"/> ECG less than 7 days old attached	
BP lying	BP standing	HR lying	HR standing	
BSL	RR	Temp	Amenorrhea: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Blood results less than 2 weeks old attached – including amylase, B12/folate, FBC, iron studies, prolactin, TFTs, U/E, LFT, calcium, Mg, phosphate, LH/FSH and estrogen, or testosterone and SHBG (required)				
Physical concerns: <input type="checkbox"/> Fainting <input type="checkbox"/> Dizziness <input type="checkbox"/> Chest pain <input type="checkbox"/> Dehydration <input type="checkbox"/> Other, specify:				
Known disabilities or impairments:				
Medical history:				
Allergies / adverse drug reactions:				
Psychiatric diagnoses / history / concerns:				

Legal issues:	
Previous admissions (medical / mental health):	
Current medications:	
SOCIAL SITUATION	FAMILY SITUATION
Accommodation:	Dependants:
Occupation:	Relationships:
Primary Language:	
PLEASE NOTE, THE MEDICAL ASSESSMENT FORM MUST BE COMPLETED PRIOR TO COMMENCEMENT WITH KARA MAAR. PLEASE ATTACH ANY RELEVANT DOCUMENTATION INC. RECENT BLOODWORK, ECG etc.	
After you have spoken with the Kara Maar Triage Officer on 08 6392 1700 send this referral to SMHS.KaraMaar.Triage@health.wa.gov.au	
If you have any further questions regarding this referral, please phone SMHS Kara Maar 08 6392 1700.	
I acknowledge:	
<input type="checkbox"/> I have read the WAEDOCS guidelines and Kara Maar GP Guide and will continue to medically monitor this consumer as per criteria.	
<input type="checkbox"/> Consumer does not require immediate admission as per WAEDOCS Indicators for Admission .	



FAMILY NAME

MRN

GIVEN NAMES

SEX MALE FEMALE

D.O.B. ____/____/____

M.O.

Service _____

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

To be completed by a medical practitioner within 12 hours of admission. If a physical examination cannot be completed within 12 hours, the reason(s) must be clearly documented below & followed up with the treating team at reasonable intervals until the examination is completed.

Date: _____ Time: _____ Location: _____ People present: _____

Did the patient give consent to a physical examination? Yes No

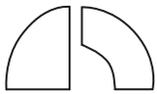
Comments: _____

SYSTEM REVIEW (e.g. relevant positive or negative history or symptoms)

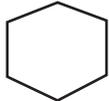
ORAL HEALTH (Consider whether an oral health check is required)

CARDIOVASCULAR (HS, JVP, Oedema, Veins, QT/QTc, ECG)

RESPIRATORY (Signs of Resp Distress, Ent, Sputum)



GASTROINTESTINAL (Jaundice/icterus, Bladder/bowel habit issues, Concern of GI bleed)



GENITOURINARY (Dysuria, Polyuria, Haematuria)

NEUROLOGICAL/MUSCULOSKELETAL

Pupils _____

Cranial nerves _____

Cerebellar signs _____

Extra pyramidal signs? _____

Medical Practitioner name: _____

Signature: _____

Designation: _____

Date: _____

Qualifications: _____



XY301100

DO NOT WRITE IN MARGIN

06/2019



FAMILY NAME

MRN

GIVEN NAMES

SEX MALE FEMALE

D.O.B. ____/____/____

M.O.

Service _____

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Mental Health
PHYSICAL
EXAMINATION

NEUROLOGICAL/MUSCULOSKELETAL (continued)

	Right	Left	Gait
Tone Upper Lower			
Power /5 Upper Lower			Is the Abnormal Involuntary Movement Scale (AIMS) test required? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reflexes Triceps Biceps Patellar Ankle Plantar			MUSCULOSKELETAL
Coordination Upper Lower			Other comments
Sensation Upper Lower			

Endocrine (Include heat/cold intolerance, diabetes)

General Appearance and Observations (e.g. major distinguishing features or injuries, use of aids - walking frame)

Pulse		Height (m)	
BP	Lying	Weight (kgs)	
Temp		BMI (kgs/m ²)	
Resp		BGL (mmol/L)	
	O ₂ Sats		

GCS ____ /15 (Eyes 1- 4, Voice 1-5, Motor 1-6)

Urinalysis _____

Urinary Drug Screen _____

SUMMARY OF FINDINGS

Medical Practitioner name:

Signature:

Designation:

Date:

Qualifications:

Physical Examination completion time:

DO NOT WRITE IN MARGIN



Government of **Western Australia**
Department of **Health**
Mental Health

FAMILY NAME

MRN

GIVEN NAMES

SEX MALE FEMALE

Service: _____

D.O.B. ____/____/____

M.O.

ADDRESS

Child & Adolescent Mental Health Service

PHYSICAL EXAMINATION

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

To be completed by a medical practitioner within 12 hours of admission.

Date:

Time:

Location:

People present:

GENERAL APPEARANCE AND OBSERVATIONS (e.g. major distinguishing features, self harm, injuries (inc. pressure injuries), use of aids. Use diagram if needed)

Height:

Weight (kg):

BMI (kg/m²):

Pulse rate:

Blood pressure:

Staff Name:

Signature:

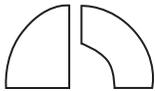
Designation:

Date:

SYSTEM REVIEW (e.g. relevant positive or negative symptoms)

CARDIOVASCULAR

RESPIRATORY



GASTROINTESTINAL



NEUROLOGICAL

 (include the following, if indicated)

Consciousness _____

Nystagmus _____

Pupils _____

Cranial Nerves _____

Fundoscopy _____

Head Circumference _____

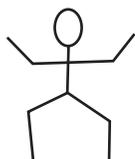
Power _____

Sensation _____

Tone _____

Reflexes _____

Gait _____



Examining Medical Practitioner:

Signature:

Designation:

Date:

CAMHS PHYSICAL HEALTH ASSESSMENT



FAMILY NAME

MRN

GIVEN NAMES

SEX MALE FEMALE

SERVICE _____

D.O.B. ____ / ____ / ____

M.O.

ADDRESS

Child & Adolescent Mental Health Service

PHYSICAL EXAMINATION

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

RESULTS OF EXAMINATION

INVESTIGATIONS ORDERED

PHYSICAL HEALTH MANAGEMENT PLAN

Examining Medical Practitioner:

Signature:

Designation:

Date: