esus·centre
Excellence in the treatment of eating disorders

Clinical Referral Form

Please email completed forms to referrals@esuscentre.au

Referrer Details			**Date**
Referrer's Full Name		Phone	
Provider Number		Email	
Practice Details			
Patient Details			
Name		Date of Birth	Sex Other
Phone	Email		
Address	Postcode		
Medicare Card Number	Individual Ref	Expiry Date	
Private Health Fund		Membership Number	

Reason for Referral

Primary Mental Health Diagnosis

Current medications

Past Medical History

Observations: Weight: Height:

Please also attach recent pathology, health summary: Lying, standing HR/BP, ECG, FBP, UEC, Mg, Ca, PO4, iron studies, BSL

Please advise which programs you would like your patient to be considered for:

Outpatient Consulting ☐ Psychology ☐ Dietetics ☐ Specialist GP ☐ Psychiatry ☐ Physiotherapy

Have you completed an Eating Disorder Treatment Plan?

Day Patient Groups

☐ Adolescent Intensive Refeeding
☐ Program Intensive Refeeding Program
☐ Dialectical Behaviour Therapy (DBT)
☐ DBT for Teenagers (14 years+)
☐ Radically Open DBT (RO DBT)
☐ Schema Therapy
☐ Soma - Integrative Therapy
☐ Soma - Post-Bariatric Surgery
☐ Unsure

Once the above information is received it will be assessed by our Referral Assessment Service (RAS) nurse and the patient contacted directly.