The Sydney children's Hospitals Network
care, advocacy, research, education

Eating Disorder Intensive Program for Adolescents (EDIPA)

REFERRAL PACKAGE

The EDIPA program is a multidisciplinary intensive treatment program designed to support young people and their family where significant difficulties progressing in treatment are being experienced.

ELIGIBITY CRITERIA

- ☐ The young person must be diagnosed with an eating disorder
- ☐ Young people must be referred before turning 16 years for treatment at SCHN
- ☐ The family must have started or have completed specific eating disorder treatment
- ☐ All young people referred to EDIPA must be linked in with a NSW Mental Health Service OR a multi-disciplinary team.
- ☐ The referring and current treating team remain involved with the patient during and after discharge from EDIPA

Complete the attached referral form and return to intake:

Clinical Nurse Consultant
SCHN Eating Disorders Service, Eating Disorder Intensive Program for Adolescents
Phone: 9382 0899 Fax: 9382 0875
Email: jo.titterton@health.nsw.gov.au

Please ensure the following items are included in the referral form:

☐ For us to assess the client we will need a separate medical referral letter from their GP addressed to Dr Ritu Datta (Paediatrician) and/or Dr Maugan Rimmer (Psychiatrist) for Medicare purposes
☐ Any previous family assessments and/or other relevant clinic letters are attached with referral
☐ Weight & Height Chart or recent data for the last 4-6 weeks
☐ A recent physical examination and relevant blood tests/investigations
☐ The contact details of key stakeholders such as family, guardian, psychiatrist, school, psychiatric or medical community services, FACS, DADHC, GP
☐ Any reports, court orders, or other information deemed relevant
☐ The family are aware of the referral and understand the process
☐ The referral is complete to avoid delays to intake process

Following the receipt of referral:

1. EDIPA will liaise with the local treating team first, and then the family to organise an initial assessment or consultation.
2. Following the initial assessment or consultation, commencement of any clinical programs will be discussed with local treating team and family.

Yours sincerely,

Dr. Lisa Dawson

Updated: May 2023

Team Leader / Clinical Psychologist

Patient details:

Name: ____________________________ DOB: ______________Age ________ Gender ___________

Patient's Medicare no: __________________ Patient's ref. no: ________________ Expiry Date: ________

School/TAFE: Grade/Year: Enrolled: ☐ Yes ☐ No Attending: ☐ Yes ☐ No

Parent/guardian: ____

Address: ____ Suburb: _________________

Post code: ___________ Home Phone: __________________ Mobile: ___________________________

Where is the patient currently? Home ☐ Hospital ☐ Other ☐

Mental Health Act Status/Guardianship:

What is the primary language spoken at home? _____________________

Young Persons family and household (Genogram)

Treatment Team

Referrer/ Therapist's details

Name: ________________________________ Position: _____________________________

Phone: _______________________________ Email: _______________________________

CAMHS team: ____

Medical lead (e.g., Paediatrician/GP): _______________________________

Psychiatrist: ____

Psychological/Family Treatment(s):

Name of organisation and **FBT** therapist: ____________________________ # of Sessions: _______

Treatment Response: (e.g. weight gain, progressed to Phase 2) ____

Previous Treatment: ____

Name of organisation and therapist: _____________________________ # of Sessions: _______

Treatment Response: ____

GP Details

Name: ___________________________ Practice: ____________________________________

Phone: __________________________ Provider No: _________________________________

Other Services Involved:

Name: ___________________________ Position: _______________________________

Phone: __________________________ Email: _________________________________

Name: ___________________________ Position: _______________________________

Phone: __________________________ Email: _________________________________

Local Eating Disorder Coordinator Details: ____

Phone No &/or Email: ____________________ *must be notified of referral* □

Psychological Information

History and Description of Eating Disorder Development
(Consider Predisposing, Precipitating and Maintaining factors)

History of Co-morbid or Other mental health issues:

Other Relevant Personal and Family History:
e.g. significant developmental history, significant life events for the young person and their family, family history of mental illness, family functioning

Current Mental State:
Include eating disorder and comorbid symptoms

Risk Assessment Summary:

Aggression ☐ Self Harm ☐ Suicide ☐ Absconding ☐ Sexual Safety Risk ☐
Child Protection ☐ Domestic Violence ☐ AOD ☐ Other (please specify) ☐
Details:

Maintaining and Protective Factors:

Factors promoting recovery: e.g. individual motivation, family's strengths

Factors impeding progress: e.g. poor attendance, poor parental unity, systemic interference, therapeutic alliance, individual factors

Aims of Treatment and any specific Consultation Question(s):

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-
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Medical Information

All patients need to be medically stable when attending the EDIPA site. It is a requirement that we receive the patient's recent medical assessment within 5 days before they come to EDIPA. If we have not received the medical information, the assessment or admission will need to be rebooked.

Eating Disorder Diagnosis: ________________________ **Duration of illness:** ____________________
Other diagnosis / co-morbidity: ____

Eating Disorder Behaviours:

Restricting: ☐ Reduced / Rigid food repertoire ☐ Excessive Exercising: ☐

Bingeing: ☐ Laxatives: ☐ Purging / Vomiting: ☐

Medical Conditions: (Please include food and other allergies)

Medications:

Current Physical Observations
Date: __________
Lying HR: __________ BP: ___________ Temp: __________
Standing HR: __________ BP: ___________
Date of last blood test: (Please attach results to the referral)

Physical Symptoms:

Dizziness ☐ Faints ☐ Abdominal Pain ☐ Constipation ☐ Other ☐
Brief details…………………………………………….

Growth and Development History:
Current Weight (kg): Height (cm): BMI: % EBW / median BMI:
Date: __________

Maximum Weight: ___________ Date: ______________
Minimum Weight: ___________ Date: ______________

Current Estimated Goal Weight (or range if known): __________kg

Date of last DEXA: (Please attach results to the referral)

Hospitalisation: (Please attach discharge summaries to the referral)
Location / dates:

In the event of a hospital admission

Admitting Hospital: ____

Please identify details of Admitting Medical Officer responsible for admission (if needed):

Name: ____________________________ Role: ________________________________

Service: ___________________________ Phone Number: ________________________