Butterfly Treatment Programs

**REFERRAL FORM**

**This referral form is for clinicians and health professionals only.**

**Date of Referral:** Click here to enter a date. **Has your client consented to this referral:** **Y** [ ]  **N** [ ]

Contact Details

**Client Details**

**Given Names:** Click here to enter text. **Surname:** Click here to enter text.

**Date of Birth:** Click here to enter a date. **Gender Identity:** Click here to enter text.

**Address:** Click here to enter text. **State Postcode**

**Contact Number: Mobile:** Click here to enter text. **Email:** Click here to enter text.

**Referrer’s Details**

**Name:** Click here to enter text. **Profession:** Click here to enter text.

**Contact Number:** Click here to enter text. **Email:** Click here to enter text.

**Practice Name:** Click here to enter text. **Practice Address:** Click here to enter text. **State Postcode**

Clinical Information

**Provisional Diagnosis:** Click here to enter text.

**Please indicate if following present:**

|  |  |
| --- | --- |
| **Behaviours** | [ ]  Restrictive food intake [ ]  Binge eating [ ]  Excessive exercise [ ]  Vomiting [ ]  Diuretics [ ]  Laxative use Other (please specify): Click here to enter text. |
| **Other Symptoms** | [ ]  Weight loss [ ]  Body image dissatisfaction [ ]  Low mood [ ]  Weight gain [ ]  Self-harm [ ]  Suicidal ideation Other (please specify): Click here to enter text. |
| **Co-Morbid Concerns** | [ ]  Depression [ ]  Anxiety [ ]  Obsessive-compulsive disorder [ ]  Trauma [ ]  Personality Disorder [ ]  Substance use – please specify: Click here to enter text.Other (please specify): Click here to enter text. |
| **Brief clinical summary, including previous ED treatment** |  |

**Medical Practitioners only**

* Patients are required to be medically stable to access our programs;
* Patients need to provide evidence of medical stability at referral stage, prior to commencing program, and at every 4 weeks thereafter;
* We **do not** provide medical monitoring and depend on the assessment of the referring medical practitioner to determine medical stability.
* All pathology (**FBC, EUC, CMP, LFT, TFT, Random glucose)** and ECG must be taken within the last 7 days of referral and results sent to Butterfly.
* If results from medical tests are outside normal limits, including the maintenance of BMI >18 kg/m2, we require a case consult with treating GP to discuss risk to client and management plan. Where a patient becomes medically unstable whilst on our program, we will work with the GP to identify a more appropriate level of care.
* A guide on “Medical Management of eating disorders” is included at the end of this referral form.

|  |  |
| --- | --- |
| Height (cm): | Weight (kg): BMI (kg/m2): |
| Lying pulse: | Standing pulse: Lying BP: Standing BP: |
| Date of last blood test: |
| Abnormal blood test results (please specify):  |
|  |
| ECG results:  |
| Medical diagnosis:  |

 **Medical Assessment**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [medical practitioner name], \_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Provider Number] confirm that all tested medical parameters (as indicated above) are within normal limits and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [patient name] is deemed to be medically stable at time of assessment.

If the patient is accepted onto Butterfly treatment programs, I agree/do not agree to provide ongoing medical management of \_\_\_\_\_\_\_\_\_\_\_\_\_\_ [patient name].

If \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [patient name]’s results from medical tests fall outside of normal limits at any stage within the duration of the program, I will advise the Butterfly Team of this and participate in a case conference to review the client’s ongoing suitability for the program.

If your patient is not medically stable, they may require hospitalisation or a higher level of care than offered at Butterfly.

Please contact Butterfly Helpline on 1800 33 4673 to identify appropriate service options.

**Signature of Referrer:  Date:** Click here to enter a date.

|  |
| --- |
| **Send completed referral form (and blood tests & ECG results if you are a GP) via:**Email: treatment@butterfly.org.au Fax: (02) 8456 3951If you have any questions, call us on (02) 8456 3916 **Thank you for your referral****We will contact the client to conduct an assessment and inform you of the outcome in writing.**  |

**Medical management of eating disorders**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Test / Investigation | Concern | Alert |  | Investigation | Concern | Alert |
| Nutrition | BMI | **< 14** | **<12** | **Bone Marrow** | WCC | **<4.0** | <2.0 |
| Weight loss per week | **>0.5kg** | **>1.0kg** | Neutrophils | **<1.5** | <1.0 |
| Albumin | **<35** | **<32** | Hb | **<110** | <90 |
| Creatinine Kinase | **>170** | **>250** | Platelets | **<130** | <110 |
| CVS | Systolic BP | **<90** | **<80** | **Electrolytes** | K+ | **<3.5** | <3.0 |
| Diastolic BP | **<70** | **<60** | Na+ | **<135** | <130 |
| Postural drop | **>10** | **>20** | Mg+ | **= 0.5 – 0.7** | <0.5 |
| Pulse | **<50** | **<40** | PO4 | **= 0.5 – 0.8** | <0.5 |
| QTc |  | **>450msec** | Urea | **>7** | >10 |
| Temperature | **<35o** | **<34.5o** | Glucose | **<3.5** | **<2.5** |  |
|  | **Liver Function** | Bilirubin | **>20** | >40 |
| ALP | **>110** | >200 |
| AST | **>40** | >80 |
| ALT | **>45** | >90 |
| GGT | >45 | >90 |

Advice from the Guidelines for the Inpatient Management of Adult Eating Disorders in General and Psychiatric Settings in NSW (2014), states that “a person with an eating disorder may be acutely medically compromised without necessarily presenting as underweight.” Above is a guide to medical instability from the Guidelines for the Inpatient Management of Adult Eating Disorders in General and Psychiatric Settings in NSW (2014) distributed by the NSW Ministry of Health.