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Butterfly Treatment Programs

**REFERRAL FORM**

This referral form is for clinicians and health professionals only. If you are interested in support for a loved one or friend, please contact archana.waller@butterfly.org.au.

**Date of Referral:** Click here to enter a date.

**Has your client consented to this referral:** **Y** [ ]  **N** [ ]

**Which program are you enquiring about?** [ ]  **Youth Program** [ ]  **Virtual Program** [ ]  **Unsure**

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.

**Contact Number: (1) Mobile:** Click here to enter text. **(2) Other:** Click here to enter text.

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

**Next of Kin Details**

**Name:** Click here to enter text. **Relationship to Client:** Click here to enter text.

**Mobile:** 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.

**Service Details:** Click here to enter text. **Location:** Click here to enter text.

**GP’s Details (if not the referrer)**

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

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

**Practice Address:** Click here to enter text.

Clinical Information

**Provisional Diagnosis (if known):** Click here to enter text.

**Height (cm):** Click here to enter text. **Weight (kg):** Click here to enter text.

**Please answer the following to the best of your knowledge:**

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| **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. |
| **Medical Diagnoses** | [ ]  Diabetes [ ]  Osteopenia [ ]  Amenorrhoea [ ]  Osteoporosis [ ]  Anaemia[ ]  Coeliac disease [ ]  Irritable Bowel Syndrome [ ]  Thyroid issues [ ]  Allergies (please specify): Click here to enter text.Other (please specify): Click here to enter text. |
| **Medications** | Please List: Click here to enter text. |

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| **Brief clinical summary (including date of onset and periods of recovery)** Click here to enter text.  |

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| ***Past* eating disorder treatment (including any day programs and psychological treatment)**Click here to enter text. ***Current* eating disorder treatment (including any day programs and psychological treatment)**Click here to enter text. |

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| **Any other relevant information (including details of any emergency department presentations or inpatient admissions)**Click here to enter text.  |

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| **Desired Outcome of Referral**Click here to enter text.  |

If you are the treating GP, we would appreciate that you continue to provide medical management for your patient.

If you are not the GP and you are not involved in continuing care, please ensure the medical management for this client has been handed over to the GP listed above.

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

**What to Do Next**

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| **Step 1: Send us the Form** | **Step 2: We’ll take it from there** |
| To complete your referral please Fax to: (02) 8456 3951Or email the completed form to: treatment@butterfly.org.auIf you have any questions please send us an email or call us on (02) 8456 3915 and leave a message.This number is attended on: Wednesday and Thursday | If we need any further information a member of the Butterfly Treatment Programs will be in contact with you. We will contact your client directly to organise a time for an Intake Call with one of our IOP Therapists.We will update you to let you know when this has been scheduled. |

**Butterfly Use Only**

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| **Date Received:** Click here to enter a date. **Triaged by:** Click here to enter text. **Accepted for Intake Assessment: Y** [ ]  **N** [ ] **Date of Intake Assessment:** Click here to enter a date. **With Therapist:** Click here to enter text.**Reason if Not Accepted:** Click here to enter text.**Referrer Notified of Outcome On:** Click here to enter a date.**Digital Signature:  Date:** Click here to enter a date. |