**SEED**

**Referral Form**

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| **S**upporting **E**arly Intervention for **E**ating **D**isorders Program (SEED) is a rapid early intervention service offering innovative, evidence-based treatment for 16 year-olds and older with an eating disorder of up to 3 years duration or no previous treatment. SEED provides a holistic, proactive, and optimistic approach. Using early access to the right treatment at the right time, SEED provides emerging adults and their families a pathway to full recovery from an ED. The SEED service model includes a rapid response to referrals, a holistic and non-stigmatising assessment, followed quickly by an evidence-based treatment plan tailored to the individual.Evidence shows that fast detection and early treatment of EDs are crucial in promoting a full recovery. It is always worth referring early. SEED supports referrals from the Clinical Hub, schools, GPs and individuals. For more information, please call us on 02 6163 7600 or seedadmin@mccg.org.au  |
| **Date of Referral**  |  |
| **Referrer (If Applicable)** | **Name:**  |
| **Organisation (if applicable):** |
| **Relationship to person being referred:**  |
| **Referrer contact details**  | **Phone:**  | **Email:**  |
| **CLIENT DETAILS** |
| **Full name of person being referred** |  |
| **Date of birth** |  | **Gender:**  |
| **Cultural Identity** |  | **Aboriginal/ Torres Strait Islander: YES/ NO** |
| **Contact details of person being referred** | **Phone:**  | **Email:** |
| **Address:** |
| **Parent/Guardian/ Next of Kin details (if applicable)** | **Name:** |
| **Relationship:** |
| **Phone:** | **Email:** |
| **REFERRAL DETAILS** |
| **Eating Disorder Symptoms**  | Please Tick where applicable: □ Restricted Eating  |  Duration of Symptoms  | Frequency of symptoms |
| □ Binge Eating |  |  |
| □ Vomiting  |  |  |
| □ Laxative Use |  |  |
| □ Excessive Exercise |  |  |
| □ Other  |  |  |
| **Are other professionals/services currently involved? If so, please list** | Professional/Service Name | Contact Details (email and phone) | Consent to be contacted by CatholicCare |
|  |  | □ Yes □ No |
| **Has the person received treatment for their eating Disorder in the past?**  | □ Yes □ No |
| **Medical Practitioner/GP Details** | **Name:** **Practice: Contact Details:** *Please note, treatment guidelines recommend that all patients with an eating disorder have ongoing engagement with a Medical Practitioner* |
| **Anthropometry Details (if known):** | Current weight:\_\_\_\_\_\_\_\_\_ kg Current height: \_\_\_\_\_\_\_\_\_ cm BMI: \_\_\_\_\_\_\_\_\_ kg/m2 Total weight: □ loss □ gain \_\_\_\_\_\_\_\_\_kg Over what time frame: \_\_\_\_\_\_\_\_ □ weeks □ months Is weight (loss/gain) still occurring: □ Yes □ No If yes, at what rate per week:\_\_\_\_\_\_\_\_ kg |
| *Please note SEED is not a crisis service, if this is a Medical Emergency please call 000. If it is a Mental Health Crisis please call Access Mental Health on 1800 629 354* |
| **Additional information which may be of assistance:***(i.e Mental Health, Drug and alcohol, medical diagnosis, current living arrangements, school/university)* |  |
| **CONSENT**  |
| **Does the person being referred consent to being contacted by CatholicCare to discuss the referral further?**   | □ Yes □ No |
| **If the person does not meet the criteria for SEED, would they wish for the referral to be forward to the Eating Disorders Clinical Hub?**  | □ Yes □ No |
| **Referrer’s signature** |  | **Date** |  |
| Please email the completed referral form to: seedadmin@mccg.org.au To speak with one of our team you can call us on 02 6163 7600. |