A logo for a company

Description automatically generated**SEED**

**Referral Form**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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](mailto: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](mailto:seedadmin@mccg.org.au)  To speak with one of our team you can call us on 02 6163 7600. | | | | | | | | | | |