

GP EATING DISORDERS PLAN (EDP)

Item Nos: 90250 - 90257

GP DETAILS			
GP Name	<UserName>	Practice Name & address	<Practice>
Provider No.	<DrProviderNo>		<DrStreet> <DrCity> <DrState>
Practice postcode	<DrPostcode>	Practice phone	<DrPhone>
	>	Practice fax	<DrFax>
GP or practice email	<DrEmail>		
GP preferred method/s of multidisciplinary team communication	<input type="checkbox"/> Letter <input type="checkbox"/> Email <input type="checkbox"/> SMS <input type="checkbox"/> Phone call <input type="checkbox"/> Other		
PATIENT DETAILS			
First Name	<PtFirstName>	Last Name	<PtSurname>
Date of Birth	<PtDoB>	Age	<PtAge>
Marital Status	<input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Married/De facto		
Current Gender Identity	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-binary <input type="checkbox"/> Not Stated <input type="checkbox"/> Transgender Female/Male-Female <input type="checkbox"/> Transgender Male/Female-Male		
Address	<PtStreet>		
Suburb	<PtCity>	Postcode	<PtPostcode>
Phone 1	<PtPhoneMob>	Phone 2	
Country of Birth		Cultural Identity	

EXAMPLE

Aboriginal or Torres Strait Islander	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither <input type="checkbox"/> Unknown
Main language spoken at home	
Proficiency in spoken English	<input type="checkbox"/> Very Well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not at All
Family/ support person details	
Consider involving support person in session if appropriate	

ELIGIBILITY FOR EDP

<p>EATING DISORDER DIAGNOSIS (DSM-V)</p> <p>https://insideoutinstitute.org.au/resource-library/dsm-5-diagnostic-criteria-for-eating-disorders</p>	<p><input type="checkbox"/> Anorexia Nervosa (AN) <i>(meets criteria for an EDP and additional eligibility criteria not necessary)</i></p> <p><input type="checkbox"/> Bulimia Nervosa (BN)</p> <p><input type="checkbox"/> Binge Eating Disorder (BED)</p> <p><input type="checkbox"/> Other Specified Feeding or Eating Disorder (OSFED) <i>must meet all other criteria</i></p>
<p>EDE-Q Global Score <i>(score ≥ 3 for eligibility)</i></p> <p>https://insideoutinstitute.org.au/assessment?started=true</p>	
<p>EATING DISORDER BEHAVIOURS <i>(at least 1 for EDP eligibility)</i></p>	<p><input type="checkbox"/> Rapid weight loss</p> <p><input type="checkbox"/> Binge eating <i>(frequency ≥ 3 times/ week)</i></p> <p><input type="checkbox"/> Inappropriate compensatory behaviour (e.g. purging, excessive exercise, laxative abuse) <i>(frequency: ≥ 3 times/week)</i></p>
<p>CLINICAL INDICATORS <i>(at least 2 for EDP eligibility)</i></p>	<p><input type="checkbox"/> Clinically underweight (< 85% expected weight with weight loss due to eating disorder) <i>Detail:</i></p> <p><input type="checkbox"/> Current or high risk of medical complications due to eating disorder <i>Detail:</i></p> <p><input type="checkbox"/> Serious comorbid psychological or medical conditions impacting function <i>Detail any psychological/ medical comorbidities and impact on health/ function:</i></p> <p><input type="checkbox"/> Hospital admission for eating disorder in past 12 months</p> <p><input type="checkbox"/> Inadequate response to evidence-based eating disorder treatment over past 6 months <i>Details:</i></p>

EDP ELIGIBILITY CRITERIA MET	<input type="checkbox"/> YES <i>health plan)</i>	<input type="checkbox"/> NO (<i>consider Better Access to mental</i>
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INITIAL TREATMENT RECOMMENDATIONS UNDER EDP

Psychological treatment services (EDPT) (Initial 10 sessions)	Dietetic services (up to 20 in 12 months)	Psychiatric/paediatriac review Assessment by psychiatrist/ paediatrician required for patient to access EDPT sessions 21-40
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Referred to:	Referred to:	Referred to:
Goals:	Goals:	
<p>Psychological treatments allowed under EDP (to be determined by MH professional):</p> <ul style="list-style-type: none"> • Family based treatment • Adolescent focused therapy • CBT • CBT-AN • CBT- BN/BED • SSCM for AN • MANTRA for AN • IPT for BN or BED • DBT for BN or BED • Focal psychodynamic therapy for EDs 		

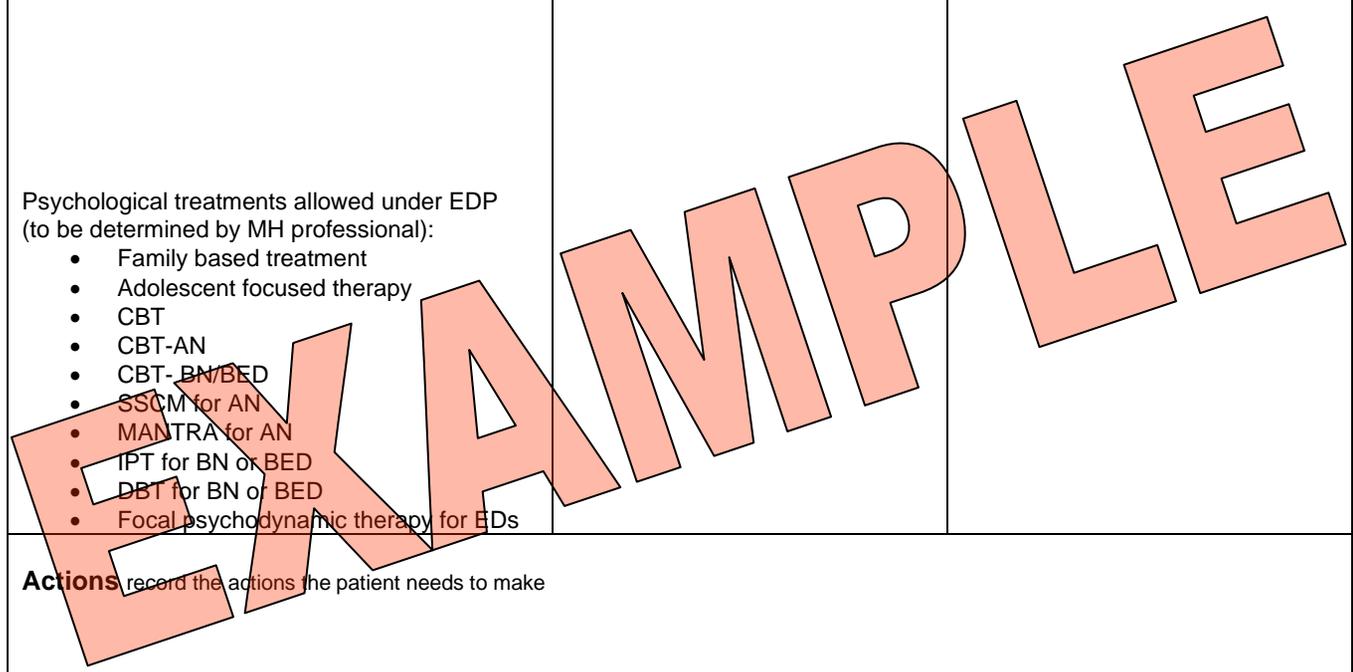
Actions record the actions the patient needs to make

Emergency Care/Relapse Prevention

Physical examination conducted (see attached)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Patient education given	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Copy of EDP given to patient	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Copy of EDP given to other providers	<input type="checkbox"/> YES	<input type="checkbox"/> NO

GP REVIEW REQUIREMENTS

- Mental health: Prior or at sessions 10, 20 & 30 of psychological treatment & at EDP completion
 - Dietetics: after Session 1 or 2 and at EDP completion
- Note: PSYCHIATRIC OR PAEDIATRIC REVIEW**



Required in addition to GP review to access sessions 21-40. Consider referring early in course of treatment

MENTAL HEALTH ASSESSMENT & HISTORY

Previous specialist mental health care	
Family History of Mental Illness	
Social history	<p>With whom does the person live?</p> <p>Highest education level completed:</p> <p>What is their employment status?</p> <p>Other Relevant Information:</p>
Personal History	(eg childhood, education, relationship history, coping with previous stressors)
Mental Status Examination	
Appearance and General Behaviour Normal Other:	Mood (Depressed/Labile) Normal Other:
Thinking (Content/Rate/Disturbances) Normal Other:	Affect (Flat/blunted) Normal Other:
Perception (Hallucinations etc.) Normal Other:	Sleep (Initial Insomnia/Early Morning Wakening) Normal Other:
Cognition (Level of Consciousness/Delirium/Intelligence)	Appetite (Disturbed Eating Patterns)
Attention/Concentration	Motivation/Energy
Memory (Short and Long Term)	Judgement (Ability to make rational decisions)
Insight	Anxiety Symptoms (Physical & Emotional)
Orientation (Time/Place/Person)	Speech (Volume/Rate/Content)

Risk Assessment			
Suicidal ideation <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES	Suicidal intent NO	<input type="checkbox"/> YES <input type="checkbox"/>
Current plan <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES	Risk to others. NO	<input type="checkbox"/> YES <input type="checkbox"/>

RECORD OF PATIENT CONSENT

I, _____, (**patient** name - please print clearly)
Agree to information about my mental and medical health to be shared between the GP and the health professionals to whom I am referred, to assist in the management of my health care.

_____ <TodaysDate>
Signature (patient): **Date:**

I (GP) have discussed the proposed referral(s) with the patient and am satisfied that the patient understands the proposed uses and disclosures and has provided their informed consent to these.

_____ <UsrName> <TodaysDate>
GP Signature **GP Name** **Date**

~~* Verbal consent documented in patient health record~~

EXAMPLE

EATING DISORDERS PATIENT PHYSICAL ASSESSMENT

SUGGESTED INITIAL PHYSICAL ASSESSMENT	<p>Height, weight, body mass index (BMI; adults), BMI percentile for age (children)</p> <p>Pulse and blood pressure, with postural measurements</p> <p>Temperature</p> <p>Assessment of breathing and breath (eg ketosis)</p> <p>Examination of periphery for circulation and oedema</p> <p>Assessment of skin colour (eg anaemia, hypercarotenaemia, cyanosis)</p> <p>Hydration state (eg moisture of mucosal membranes, tissue turgor)</p> <p>Examination of head and neck (eg parotid swelling, dental enamel erosion, gingivitis, conjunctival injection)</p> <p>Examination of skin, hair and nails (eg dry skin, brittle nails, lanugo, dorsal finger callouses [Russell's sign])</p> <p>Sit-up or squat test (ie a test of muscle power)</p>
USEFUL LABORATORY INVESTIGATIONS	<p>Full blood count</p> <p>Urea and electrolytes, creatinine</p> <p>Liver function tests</p> <p>Blood glucose</p> <p>Urinalysis</p> <p>Electrocardiography</p> <p>Iron studies</p> <p>B12, folate</p> <p>Calcium, magnesium, phosphate</p> <p>Hormonal testing – thyroid function tests, follicle stimulating hormone, luteinising hormone, oestradiol, prolactin</p> <p>Plain X-rays – useful for identification of bone age in cases of delayed growth</p> <p>Bone densitometry – relevant after 9–12 months of the disease or of amenorrhoea and as a baseline in adolescents. The recommendation is for two-yearly scans thereafter while the DEXA scans are abnormal.</p>