

GP EATING DISORDERS PLAN (EDP)

Item Nos: 90250 - 90257

GP DETAILS				
GP Name Provider No.		Practice Name & address		
Practice postcode		Practice phone	Practice fax	
GP or practice email				
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		Last Name		
Date of Birth		Age		
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				
Suburb		Postcode		
Phone 1		Phone 2		
Country of Birth		Cultural Identity		
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	
EATING DISORDER DIAGNOSIS (DSM-V) https://insideoutinstitute.org.au/resource-library/dsm-5-diagnostic-criteria-for-eating-disorders	<input type="checkbox"/> Anorexia Nervosa (AN) (<i>meets criteria for an EDP and additional eligibility criteria not necessary</i>) <input type="checkbox"/> Bulimia Nervosa (BN) <input type="checkbox"/> Binge Eating Disorder (BED) <input type="checkbox"/> Other Specified Feeding or Eating Disorder (OSFED) <div style="float: right; margin-left: 20px;"> } <i>must meet all other criteria</i> </div>
EDE-Q Global Score <i>(score ≥ 3 for eligibility)</i> https://insideoutinstitute.org.au/assessment?started=true	
EATING DISORDER BEHAVIOURS <i>(at least 1 for EDP eligibility)</i>	<input type="checkbox"/> Rapid weight loss <input type="checkbox"/> Binge eating (<i>frequency ≥ 3 times/ week</i>) <input type="checkbox"/> Inappropriate compensatory behaviour (e.g. purging, excessive exercise, laxative abuse) (<i>frequency: ≥ 3 times/week</i>)
CLINICAL INDICATORS <i>(at least 2 for EDP eligibility)</i>	<input type="checkbox"/> Clinically underweight (< 85% expected weight with weight loss due to eating disorder) <i>Detail:</i> <input type="checkbox"/> Current or high risk of medical complications due to eating disorder <i>Detail:</i> <input type="checkbox"/> Serious comorbid psychological or medical conditions impacting function <i>Detail any psychological/ medical comorbidities and impact on health/ function:</i> <input type="checkbox"/> Hospital admission for eating disorder in past 12 months <input type="checkbox"/> Inadequate response to evidence-based eating disorder treatment over past 6 months <i>Details:</i>
EDP ELIGIBILITY CRITERIA MET	<input type="checkbox"/> YES <input type="checkbox"/> NO (<i>consider Better Access to mental health plan</i>)

INITIAL TREATMENT RECOMMENDATIONS UNDER EDP		
Psychological treatment services (EDPT) (Initial 10 sessions)	Dietetic services (up to 20 in 12 months)	Psychiatric/paediatic review Assessment by psychiatrist/ paediatrician required for patient to access EDPT sessions 21-40
Referred to: Goals:	Referred to: Goals:	Referred to:
Psychological treatments allowed under EDP (to be determined by MH professional): <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		
<input type="checkbox"/> Mental health: Prior or at sessions 10, 20 & 30 of psychological treatment & at EDP completion		
<input type="checkbox"/> 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	With whom does the person live? Highest education level completed: What is their employment status? Other Relevant Information:
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	Suicidal intent	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Current plan	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Risk to others.	<input type="checkbox"/> YES	<input type="checkbox"/> NO

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.

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.

GP Signature

GP Name

Date

EATING DISORDERS PATIENT PHYSICAL ASSESSMENT

<p>SUGGESTED INITIAL PHYSICAL ASSESSMENT</p>	<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>
<p>USEFUL LABORATORY INVESTIGATIONS</p>	<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 B12, folate 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 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>