AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

KARI CENTRE
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KARI CENTRE

Eating Disorder Additional Information

Date: .....

Note: It may be easier to fill this form out during consultation with your client.

CLIENT NAME:	NHI:
Address:	
Telephone:	

Date of birth: ..... Age: .....

Ethnicity: ..... Male / Female

Country of birth: ..... NZ Resident: Yes / No

Occupation: ..... Current living situation: .....

REFERRER:
Address:
Telephone:

Who initiated referral: .....

Is client aware of referral: ☐ Yes ☐ No

Diagnosis:

Previous or current treatment for eating disorder: .....

Vital Signs:

(Date: _____)

Blood pressure _____ Lying _____ Standing

Heart Rate _____ Lying _____ Standing

Temperature _____

Hydration *(e.g. JVP, tissue turgor)* _____

Weight History:

- Height:
- Current weight:
- BMI = $\frac{\text{Weight: (kg)}}{\text{Height (m)}^2}$:
- Lowest weight (*when*):
- Highest weight (*when*):
- Weight 3 months ago:
- Weight 6 months ago:

Pre-pubescent / Menstruation / Amenorrhoea (since when):

Age of Menarche: _____ years old

Is patient currently on contraceptives? ☐ Yes ☐ No

Eating Behaviour:	**Date of onset**	**Frequency at onset**	**Frequency now**	**Comments**
• Restricting				
• Bingeing (*quantity of food*)				

Compensatory Behaviour:	**Date of onset**	**Frequency at onset**	**Frequency now**	**Comments**
• Vomiting				
• Laxative abuse *(which kind, quantity)*				
• Exercise				
• Fluid intake				

Underlying feelings and thoughts:

- Fear of becoming fat ☐ Yes ☐ No
- Distorted body image ☐ Yes ☐ No

Alcohol and Drugs:	**Quantity**			**Duration**	**Comments** *(Including previous treatment)*
	Per day	**Per week**	**Per month**		
• Alcohol *(binge drinking, blackouts)*					
• Cigarettes					
• Other Drugs *(which kind)*					

Physical Signs and Symptoms *(please check if present)*:

- ☐ Abdominal pain
- ☐ Abdominal bloating
- ☐ Cold intolerance
- ☐ Constipation
- ☐ Dizziness
- ☐ Fatigue
- ☐ Palpitations
- ☐ Weakness

Current and Past Medical History:

Current and Past Psychiatric History:

- e.g. anxiety, depression, PTSD symptoms or trauma history, obsessive compulsive behaviours, self-harm, suicidality, suicide attempts (*please note whether current or historical*):

- Previous treatment(s) for the above *(please list)*: e.g. counselling, medication

Current Medication:

Allergies:

Motivation to change eating behaviour now:

Self-rating by patient:
Rating by clinician:

Low 1 2 3 4 5 6 7 8 9 10 High

Further comments:

► **Referral must include the following blood tests:**

- ☐ Full Blood Count
- ☐ LFTs (liver group)
- ☐ LH + FSH
- ☐ Glucose
- ☐ Calcium
- ☐ Magnesium
- ☐ Renal Function (including K+, Na+, Creatinine, Urea)
- ☐ Protein and Albumin
- ☐ Thyroid Hormones (including TSH, T3, T4)
- ☐ Iron Studies (including Ferritin)
- ☐ Phosphate
- ☐ B12

Please check that all of the information on this form is filled out as this is pivotal in processing the referral.