EMR503560

Government of **Western Australia**
Child and Adolescent Health Service

Physical Health Review Form (Please write/print clearly) – Eating Disorders Service

Current Review Date: _____ Last review date: _____

Food intake: _____

Fluid intake: _____

WEIGHT CONTROLLING BEHAVIOURS: (frequency, intensity, duration)

Fasting		Laxative use	Yes ☐	No ☐
Vomiting		Diuretic use	Yes ☐	No ☐
Exercise *(type, intensity, duration, frequency)*		Pre syncopal episodes	Yes ☐	No ☐
Eating Disorder cognitions - detail		Warmth of extremities	Cold ☐	Warm ☐
Engagement with treatment plan - detail		Colour of extremities	Pale ☐	Blue ☐
		Alcohol and other drug use	Yes ☐	No ☐

FREQUENCY OF BINGE EATING BEHAVIOUR

None	1-3 Episodes per week	4-7 episodes per week	8-13 episodes per week	14 or more episodes per week

CURRENT MEDICATIONS: _____

CLINICAL EXAMINATION: **Temperature:** _____

Lying after 5 minutes: Pulse: _____ Blood Pressure: _____

Standing after 1 minute: Pulse: _____ Blood Pressure: _____

Weight (shoes off): _____ Weight change since last review: _____

Highest ever weight (inc. date): _____ Lowest ever weight (inc. date): _____

Height (shoes off): _____ BMI: _____ Median %BMI: _____

Investigations (Please attach): Electrolytes ☐ LFT ☐ U&E ☐ Mag ☐ Phos ☐ Calcium ☐ FBP ☐

ECG ☐ QTc _____ HR _____

Patient menstruating? YES ☐ NO ☐ Primary/Secondary Amenorrhea LNMP: _____

Deliberate Self Harm? YES ☐ NO ☐ Suicidal ideations? YES ☐ NO ☐ If yes, please attach management plan

Mental Health/Other Diagnoses: _____

Current mental health care/Eating Disorder Management Plan: YES ☐ NO ☐

Service Provider: _____ Consent to liaise YES ☐ NO ☐

Other comments/Next Review: _____

Signature: _____

Thank you for your feedback, we will contact you if appropriate.
If you wish to discuss this referral further, please contact the EDS Triage Officer on 6456 0201