Physical assessment for eating disorders

The Geelong Clinic
by Healthscope

This form is to be completed by the referring doctor. Please return to The Geelong Clinic via fax on 03 5240 0799.

Date:		
Patient name:	Date of birth:	
Blood pressure sitting:	Blood pressure standing:	
Heart rate sitting:	Heart rate standing:	
Current weight:	Height:	Current BMI:
Weight change in past month:	Weight change in past six months:	
Temperature:	*** Please ensure the influenza vaccine is given if in winter months**	

Eating Disorders Behaviours (frequency/week)
Binge eating:
Purging (vomiting):
Exercising:
Laxative use:

Symptoms	Yes	No	Signs	Yes	No	Investigations (*within one week of admission)	Yes	No
Amenorrhoea	☐	☐	Pallor	☐	☐	*ECG	☐	☐
Fractures	☐	☐	Peripheral cyanosis	☐	☐	*FBC	☐	☐
Dizziness	☐	☐	Ankle oedema	☐	☐	*U&E	☐	☐
Palpitations	☐	☐	Lanugo	☐	☐	*Ca/Mg/Phosphate	☐	☐
Syncope	☐	☐	Knuckle calluses	☐	☐	*NON-fasting glucose	☐	☐
Constipation	☐	☐	Parotid swelling	☐	☐	LFT	☐	☐
Bloating	☐	☐	Recent self-harm wounds	☐	☐	Vitamin B12 level in the past 12 months	☐	☐
Reflux	☐	☐				Iron studies	☐	☐
Any viral/COVID-19 Symptoms	☐	☐				Vitamin D level	☐	☐
						TSH	☐	☐
						Bone density scan	☐	☐
						*Covid-19 swab	☐	☐

Please attach a record of current medical conditions and medications.
Thank you for completing this form. It helps to determine the safety of admitting your patient to our program.

The Geelong Clinic
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