LUMA FOR HER HEALTH AND WELLBEING

Body Esteem Youth Program (BE-YP):

REFERRAL FORM

Client name: ____________________ Aged 16-20yrs ☐

Date of birth: ____________ Gender: ____________ Preferred pronouns: ____________

Address: ____________________ Suburb: ____________

Email: ____________________ Mobile: ____________

☐ I confirm the client named above has consented to this referral **or** ☐ I am self-referring

The BE YP is delivered alongside a (separate) Parent/Carer program. Please provide the details of a nominated support person the client may wish to attend:

Name: ____________________ Mobile: ____________

Relationship to client: ____________________

☐ I (client), give permission for the above support person to liaise with the BEP team for the purposes of organising my Intake Assessment.

GP DETAILS

Doctor: ____________________ Practice: ____________

Email: ____________________ Phone: ____________

REFERRER DETAILS (IF NOT GP)

Name: ____________________ Organisation: ____________

Email: ____________________ Phone: ____________

☐ I (client), give permission for the BEP team to liaise with the referrer regarding this referral.

CURRENT EATING DISORDER EXPERIENCE/DIAGNOSIS:

☐ Anorexia Nervosa (AN) ☐ Bulimia Nervosa (BN) ☐ Binge Eating Disorder (BED)

☐ Other Specified Feeding or Eating Disorder (OSFED) ☐ Other ____________

OTHER PRESENTING ISSUES OR ADDITIONAL INFORMATION/COMMENTS:

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REFERRER ACKNOWLEDGEMENT

☐ I (referrer), acknowledge that Body Esteem Program is a **recovery focused, peer support program.**

Signature: ____________________ Date: ____________

Please submit this referral to Luma's Body Esteem Program via BEP@luma.org.au