LUMA FOR HER HEALTH AND WELLBEING

Body Esteem Youth Program (BE-YP):

REFERRAL FORM

Body esteem program
A Community Eating Disorders Service

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:

_____

_____

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