Body Esteem Youth Program (BE-YP): Referral Form

PARTICIPANT DETAILS

Name: _____ **Date of birth:** _____

Address: _____ **Suburb:** _____

Email: _____ **Mobile:** _____

Gender: _____ **Pronouns:** _____

☐ I confirm the Participant has consented to this referral ☐ Self-Referral

The BE-YP is delivered alongside a separate Parent/Carer group. Please provide details of a nominated support person who the Youth Participant may wish to attend:

Name: _____ Mobile: _____

Relationship to Youth Participant: _____

☐ I, the Youth Participant, give permission for the above person to liaise with the BEP team for the purposes of organising my Intake Assessment.

GP DETAILS

Doctor: _____ Practice: _____

Address: _____ Suburb: _____

Email: _____ Phone: _____

REFERRER DETAILS (IF NOT GP)

Name: _____ Organisation: _____

Address: _____ Suburb: _____

Email: _____ Phone: _____

Current eating disorder experience/diagnosis:

- ☐ Anorexia Nervosa (AN)
- ☐ Bulimia Nervosa (BN)
- ☐ Binge Eating Disorder (BED)
- ☐ Other Specified Feeding or Eating Disorder (OSFED)
- ☐ Other, please specify: _____

Eating disorder behaviours — does the Participant engage in:

Restrictive intake:	☐ No	☐ Yes	
Frequently consuming large amounts of food and feeling unable to stop:	☐ No	☐ Yes	Frequency: _____
Compensatory behaviours including:			
Purging:	☐ No	☐ Yes	Frequency: _____
Compulsive exercise:	☑ No	☐ Yes	Frequency: _____
Laxative use:	☐ No	☐ Yes	Frequency: _____
Other: _____	☐ No	☐ Yes	Frequency: _____

Other presenting issues or additional information/comments:

_____

_____

_____

Other services involved in treatment:

_____

_____

_____

REFERRER ACKNOWLEDGEMENT

☐ I acknowledge that Body Esteem Program is a **recovery focused, peer support program, not a clinical treatment program.**

Sign: _____ Date: _____