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REFERRAL TO WOMEN'S RECOVERY NETWORK (Wren) FOR ADMISSION

Participant details					
Last name*		First name/s*		Date of birth*	

*mandatory fields

- Wren supports women living in Victoria aged 18 years and over, with a range of issues including experiences of trauma and abuse, eating disorders and perinatal mental health concerns
- The participant will be contacted on receipt of this referral

Enquiries / return referral to: T 03 9279 3759 F 03 9256 8364 E referral@womensrecovery.org.au

- Complete this referral electronically (all fields are interactive)

Care stream participant is being referred to			
☐ General	*Do not complete Appendix A or B*		
☐ Perinatal	*Complete Appendix A*		
☐ Eating Disorders	*Complete Appendix B*		
Participant has verbally consented to this referral*	☐ Yes ☐ No	**Referral date***	

Participant information					
Sex	☐ Female ☐ Male ☐ Other	Gender identity	☐ Female ☐ Male ☐ Non binary ☐ Not stated ☐ Prefer not to answer		
Marital status	☐ Never married ☐ Divorced ☐ Widowed ☐ Separated ☐ Married / De facto ☐ Not stated ☐ Prefer not to answer			Religion	☐ Not stated ☐ Prefer not to answer
Address					
Telephone/s		Email			
Preferred method of communication	☐ Email ☐ Telephone ☐ SMS ☐ Letter ☐ Exclude mail out				
Medicare number		Ref	Exp	NDIS number	
Private health insurance	☐ Yes ☐ No	If yes, fund name & number			
Interpreter	☐ Yes	Language			
Indigenous status	☐ Not Aboriginal or Torres Strait Islander ☐ Torres Strait Islander not Aboriginal ☐ Aboriginal not Torres Strait Islander	☐ Aboriginal and Torres Strait Islander ☐ Prefer not to answer ☐ Not specified			
Cultural considerations / support needs					
Is the participant pregnant? If yes, what is the due date? Any known complications? History of pre-term delivery?					
Any dependents / children in their care?	☐ Yes, *details*				
Contact / support person	Name				
	Relationship		Telephone		
Nominated Support Person	Name				
	Relationship		Telephone		
Advance Statement of preferences	☐ Yes ☐ No	*If yes, attach*			

Current supports	Name	Address
General Practitioner		
Psychiatrist		
Psychologist		
Area Mental Health Service		
Maternal Child Health Nurse		
Dietitian		
Antenatal care (*if applicable*) Last visit:		
Other (*eg, NDIS coordinator*)		

Sept 2024
Source: AlfredHealth.org.au

EMR: Admission / Admission Request

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Last name*		First name/s*		Date of birth*	

Referrer Details					
Referring clinician name				Designation	
Organisation name and address					
Telephone		Fax		Email	

Referral	
Reason for referral (*what are the presenting problems? What would you like to address?)*	
Goals for admission (*what would you/the participant like to achieve from the admission?)*	
Mental Health history* (*including diagnosis, previous admissions & treatment)*	
Alcohol or drug history & current use (any *alcohol or other non prescription drug use in the last 3 weeks?)*	
Medical history*	
Current physical health problems	
Current medications / doses* (*incl over the counter medications)*	

*separate documents can be attached

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Risk Assessments		
Suicide	Imminent ☐ Yes ☐ No *Details*	High ☐ Yes ☐ No
Deliberate Self Harm	Imminent ☐ Yes ☐ No *Details*	High ☐ Yes ☐ No
Harm to others	Imminent ☐ Yes ☐ No *Details*	High ☐ Yes ☐ No
Other risks, incl family violence, absconding, vulnerabilities	☐ Yes *details*	

Attach any relevant background information eg, discharge summaries, management plans, assessments

Legal / forensic	
Current forensic or legal status (*incl child protection order, IVOs*)	
To the best of your knowledge, have any Child Protection notifications been made?	☐ Yes ☐ No *details*
Case worker and contact (*if applicable*)	

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Appendix A: Perinatal Stream

Child name	DOB	Age	Sex	Breastfeeding
			☐ F ☐ M	☐ Y ☐ N
			☐ F ☐ M	☐ Y ☐ N

Are there any concerns about the physical health or behaviours of the child to be admitted? Specify the gestational age at birth if the child was premature and if there is any ongoing active treatment required *eg. NG feeding*	☐ Yes *details*
Does the child to be admitted co-sleep with the parent?	☐ Yes *details*
Risk of harm to child / children	Imminent ☐ Yes ☐ No High ☐ Yes ☐ No *Details*
Comment on the participants ability to care for the child independently and/or what supports are currently required.	

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Appendix B: Eating Disorders Stream

Diagnosis	☐ Anorexia nervosa	☐ Avoidant/Restrictive Food Intake Disorder (ARFID)	☐ Other Specified Eating Disorder (OSFED)
	☐ Bulimia nervosa	☐ Binge Eating Disorder (BED)	

Weight (kg)		**Height (cm)**		**BMI (kg/m^2)**		**Measurement date** (*within 2 weeks of referral*)	

Disordered Eating Behaviours	Provide details if present: frequency, duration, quantity
Current oral intake *(food and fluid)*	
Binge eating	
Purging/vomiting	
Laxative use	
Diuretic use	
Use of diet or weight loss medications *(eg.Metformin, GLP-2 Agonists, duromine, thyroxine/insulin, Saxenda)*	
Exercise	
Body image and body checking	
Preoccupation with weight / shape	
Other weight control behaviours	
Weight loss trajectory	
Goals of admission (*be specific as possible – eg, weight restoration, challenge a particular eating disorder behaviour)*	

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Last name*		First name/s*		Date of birth*	

Physical Assessment *(within 2 weeks of referral)*				
Date of assessment				
Assessor name and role				
Blood Pressure	Lying		Standing	
Heart Rate	Lying		Standing	
Temperature		Random Blood Glucose Level		
Palpitations/chest pain	☐ Yes			
Syncope/fainting	☐ Yes			
Postural dizziness	☐ Yes			
Dyspnoea	☐ Yes			
Muscle weakness	☐ Yes			
Constipation	☐ Yes			
Amenorrhoea	☐ Yes			

Investigations *(attached results)*	**Essential** ☐ Bloods (*incl FBA, UEC, LFT, CMP, BSL)* ☐ ECG	**Preferable** ☐ Bone density / DEXA scan ☐ Weight / height trajectory chart
Inpatient medical admission within the last month?	☐ Yes *(list dates & facility)*	

If the participant has had a recent inpatient medication admission outside of Alfred Health, attach		
☐ Food and fluid balance chart	☐ Meal plan / treatment from dietician	☐ Bowel Chart
☐ Medication chart	☐ Current MDT / care plans	☐ Sleep Chart
☐ Discharge Summary		