Assessment and Intake Form

Date: _____

Patient's Name: _____ DOB ___/___/___ Age ____ Sex ____

Address: _____ Tel: (h) _____

_____ (w) _____

Referred by: _____ Tel: _____

Address: _____

_____

Reason: _____

_____

_____

Weight _____ (kg) Height _____ (cm) BMI _____ (kg/m^2)

Max. Weight _____ (kg) Date ___/___/___

Min. Weight _____ (kg) Date ___/___/___

Eating disordered behaviours: Vomiting _____ Restricting _____ Exercising _____ Bingeing _____

Purging _____ Exercising _____ Laxatives _____ Other _____ Binging (Y/N) frequency _____

Vital signs: Heart rate _____ BP _____ Temperature _____ ECG findings _____

Menarche (Y/N) Date ___/___/___ Length of amenorrhoea _____

Laboratory Results _____

_____

Medication _____

Previous Interventions/Services _____

Figure 7.1 Useful information to collect when triaging patients at initial referral