



Central Region Eating Disorder Services (CREDS)

PRE ASSESSMENT MEDICAL REVIEW FORM

- ➤ As part of the CREDS referral and assessment process we require all clients to be reviewed by a medical practitioner, and the following form to be completed in full
- > It is important that all this information is current and gathered on the same day
- > Please ask the lab to forward blood results, and Cardiology to forward copies of the ECG to CREDS

Client name and NHI:		Findings	Indicators of medical instability Consider medical admission if-	
Pulse and B.P.	Lying (after 5 mins)	Pulse: B/P:	Pulse < 45: BP <80 sys. <40 dia.	
	Standing (after 2 mins)	Pulse: B/P:	or if change on standing >25	
ECG (please send copy to CREDS)			Bradycardia or prolonged QTC	
Temperature			< 35.5	
Hydration				
Peripheral status / circulation			Abnormal	
Weight	Current		> 20% of body weight lost within a 6	
	Minimum		month period;	
	Maximum		< 85% of 'normal' weight for developmental stage	
	Duration of weight loss			
Height				
BMI: (WT ÷ HT ÷ HT)			< 14	
Menstruation			> 3 months Amenorrhoea	
Is oedema present?		Yes/No	Where?	
Has client been purging?		Yes/No	How often?	
Has client been bingeing?		Yes/No	How often?	
Has client been exercising ++?		Yes/No	How often?	
Blood work	Full blood count	Lab form sent to lab requesting copies of results to be sent to CREDS?	Yes	
	Electrolytes	Current Medications:		
	К			
	Phosphate	1		

Is the client involved with a mental health service or professional?

If yes, who?

Have they had previous support from a mental health service or professional?

If yes, who?

BRIEF MENTAL STATE GUIDE

Does client engage in deliberate self-harm?	Yes/No	What, when and how often?
Does client feel depressed/have thoughts that life isn't worth living?	Yes/No	How do they describe this?
Does client have/had thoughts of suicide?	Yes/No	If currently - how often?
If yes, do they have a plan and intent to carry it out?	Yes/No	How and when?
Does client feel unsafe at the moment?	Yes/No	Do their support people know?
Does client know anyone who has suicided, in particular family members?	Yes/No	Who and when?
Has client been misusing alcohol and drugs?	Yes/No	Details:
Does client experience anxiety/panic attacks?	Yes/No	How often and where?
Is client sleeping adequately?	Yes/No	If no, what is their sleep pattern?
Does client have thoughts of harming others, including family?	Yes/No	Who and how?
Did something trigger the current feelings of distress/disordered eating habits?	Yes/No	Details:
Does client have any other symptoms of concern? (eg accelerated/slowed speech; activity; mood; thought processes; or delusions/hallucinations)?	Yes/No	Details:

If a number of the above answers are yes, please discuss with the client a joint referral being made to a mental health service/mental health professional.

Has a referral to another service been made		Yes/No If yes, to whom? _	
Exam date/time:	Doctor	's name completing	this exam:
Doctors practice:	Phone: Email:		Fax:

Please return this form via post or email to: CREDS, Private Bag 31907, Lower Hutt

creds@mhaids.health.nz