

To: **Elemental Collective**
 Address: **Suite 101/134-136 Cambridge Street, Collingwood VIC, Australia**
 Date: **25/05/2025**
 Dear **Ana Ximena Torres**
 RE: **Darcy** **Deligiannoudis** **DOB: 06/03/2001**

Please find below an Eating Disorder Care Plan (EDP) prepared for this patient with details of their condition. This referral covers sessions 1-10 for psychological intervention, 1-20 for a dietitian, after which I will review and provide ongoing referrals as appropriate. Many thanks for your care and for your ongoing collaboration and communication.

Yours sincerely,

Name: **Lindsay Hyde**

Date: **25/05/2025**

GP EATING DISORDER PLAN (EDP)

Item No : 90250 – 90257 [MBS Quick reference](#)

GP DETAILS			
GP Name	Lindsay Hyde	Practice Name & Address	Dr. Lindsey Hyde Reservoir Medical Group Summerhill Shopping Centre 27/850 Plenty Rd. RESERVOIR 3073 Prov. No. 036712AX PH: 8470 5888 Fax: 9471 9452
Provider No.	036712Ax		
Practice Phone	Dr. Lindsey Hyde Reservoir Medical Group Summerhill Shopping Centre 27/850 Plenty Rd. RESERVOIR 3073 Prov. No. 036712AX PH: 8470 5888 Fax: 9471 9452	Practice Fax	
GP Health Identifier			
GP Email	admin@reservoirmedical.com.au		

PATIENT DETAILS			
First Name (as on Medicare)	Darcy	Last Name	Deligiannoudis
Preferred Name	Darcy	Marital Status	N/A
Date of Birth	06/03/2001	Age	24
Gender Identity	As identified in software: Current identity <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female <input type="checkbox"/> Non-binary/Gender fluid <input type="checkbox"/> Different identity		
Address	138 North Road, Reservoir		
Phone (h)		Phone (m)	0401171166
Cultural Identity		Aboriginal or Torres Strait Islander	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
First Language	Interpreter needed? <input type="checkbox"/> Yes		
Family/ Support Person Details (Consider involving support person in session if appropriate) InsideOut resources for carers Butterfly resources for carers NEDC resources for carers	Name: Relationship to patient: Pt consent to contact given <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Ph: <input type="checkbox"/> Very well supported <input type="checkbox"/> Well supported <input checked="" type="checkbox"/> Somewhat supported <input type="checkbox"/> Not supported Any information not to be shared with support person:		
Relevant Current Medications			

ESTABLISH ACCESS TO EDP (If not appropriate consider using a MHCP or GPMP)

<p>Eating Disorder Diagnosis (DSM-V)</p> <p>InsideOut GP HUB & diagnostic guides</p>	<p><input checked="" type="checkbox"/> Anorexia Nervosa (AN) <i>(Criteria met for EDP)</i></p> <p><input type="checkbox"/> Bulimia Nervosa (BN) <i>(Other criteria needed, see below)</i></p> <p><input type="checkbox"/> Binge Eating Disorder (BED) <i>(Other criteria needed, see below)</i></p> <p><input type="checkbox"/> Other Specified Eating or Feeding Disorder (OSFED) <i>(Other criteria needed, see below)</i></p>
<p>EDE-Q Global Score</p> <p>InsideOut - EDE-Q online with scoring</p>	<p>EDE-Q Score: (greater than or equal to 3 to access EDP for BN, BED or OSFED)</p> <p>4</p>
<p>Eating Disorder Behaviours</p> <p>(At least one needed to access EDP and rebates for BN, BED or OSFED)</p>	<p>Eating disorder behaviours:</p> <p><input type="checkbox"/> Rapid weight loss <input type="checkbox"/> Binge eating (frequency ≥ 3 times per week)</p> <p><input type="checkbox"/> Compensatory Behaviour (frequency ≥ 3 times per week)</p> <p>Type of compensatory behaviours (if relevant):</p> <p><input type="checkbox"/> Purging <input type="checkbox"/> Excessive exercise <input type="checkbox"/> Laxative abuse <input checked="" type="checkbox"/> Restriction/Fasting <input type="checkbox"/> N/A</p> <p>Frequency of behaviour:</p> <p><input type="checkbox"/> N/A <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly</p>
<p>Clinical Indicators</p> <p>(At least 2 to access EDP and rebates for BN, BED or OSFED)</p>	<p>Clinical Indicators:</p> <p><input type="checkbox"/> Clinically underweight (less than 85% expected weight with weight loss due to an ED)</p> <p><input type="checkbox"/> Current or high risk of medical complications due to ED</p> <p><input type="checkbox"/> Serious comorbid psychological/medical conditions impacting function</p> <p><input type="checkbox"/> Hospital admission for an ED in past 12mths</p> <p><input type="checkbox"/> Suboptimal response to evidence based treatment over past 6mths</p> <p><input type="checkbox"/> N/A</p>
<p>Access to EDP Established</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (consider Better Access to Mental Health Plans)</p>

MENTAL HEALTH ASSESSMENT & HISTORY

<p>Previous Specialist Mental Health Care</p>	<p>Mind Body Well</p>
<p>Social & Family History</p>	
<p>Personal History</p> <p>Childhood, education, relationship history, previous stressors, protective factors</p>	
<p>Results of Mental State Examination</p> <p>Detail findings</p> <p>Mental state examination</p>	<p>Appearance: Normal</p> <p>General behaviour: Normal</p> <p>Speech: Normal</p> <p>Mood: Normal</p> <p>Affect: Normal</p> <p>Thought: Weight, ADHD</p> <p>Perceptions: Normal</p> <p>Cognition: Normal</p> <p>Insight: Yes</p>

Risk Assessment Note any identified risks Blackdog Institute resources	Identified risk: <input type="checkbox"/> Suicidal ideation <input type="checkbox"/> Suicidal intent <input type="checkbox"/> Current plan <input type="checkbox"/> Medical risk <input checked="" type="checkbox"/> None <input type="checkbox"/> Other
	Plan for managing risk: <input checked="" type="checkbox"/> Mental Health Line <input type="checkbox"/> After hours GP service <input type="checkbox"/> Family monitoring <input checked="" type="checkbox"/> GP monitoring <input type="checkbox"/> Other

MEDICAL REVIEW

Examination As indicated	Physical examination done: <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Height, weight, BMI (adults) BMI percentile (children) <input type="checkbox"/> Pulse & blood pressure, with postural measurements <input type="checkbox"/> Temperature <input type="checkbox"/> Assessment of breathing & breath (e.g. ketosis) <input type="checkbox"/> Examination of periphery for circulation and oedema <input type="checkbox"/> Assessment of skin colour (e.g. anaemia, hypercarotenaemia, cyanosis) <input type="checkbox"/> Hydration state (e.g. moisture of mucosal membranes, tissue turgor) <input type="checkbox"/> Examination of head & neck (e.g. parotid swelling, dental enamel erosion, gingivitis, conjunctival injection) <input type="checkbox"/> Examination of skin, hair & nails (e.g. dry skin, brittle nails, lanugo, dorsal finger callouses (Russell's sign)) <input type="checkbox"/> Sit up or squat test (i.e. test of muscle power) Investigations done: <input checked="" type="checkbox"/> FBC <input checked="" type="checkbox"/> EUC/LFT/CMP/BSL <input checked="" type="checkbox"/> Urinalysis <input checked="" type="checkbox"/> Electrocardiography <input checked="" type="checkbox"/> Iron studies, B12, folate <input checked="" type="checkbox"/> E/P, LH/FSH, if appropriate TSH/Prl <input type="checkbox"/> Bone densitometry – relevant after 9-12mths of disease or of amenorrhoea & as baseline in adolescents (recommendation is for 2yrly scans thereafter while DEXA scans are abnormal)
Observations	
Psychological / medical comorbidities	ADHD
Medical complications	
Protective factors	Good family + mental health support
Emergency care / relapse prevention	Mental health worker, SP, Beyond Blue, CAT team

INITIAL TREATMENT RECOMMENDATIONS UNDER EDP		
Psychological treatment services (EDPT) (Initial 10 sessions)	Dietetic services (up to 20 in 12 months)	Psychiatric/paediatric review Assessment by psychiatrist/ paediatrician required for patient to access EDPT sessions 21-40
Referred to: Ana Ximena Torres Phone: N/A Goals: hello@elementalcollective.com.au	Referred to: Phone: Goals:	Referred to: Phone:
Psychological treatments allowed under EDP (to be determined together with MH professional): • Family based treatment, Adolescent focused therapy, CBT, CBT-AN, CBT-E, SSCM for AN, MANTRA for AN, IPT for BN or BED, DBT for BN or BED, Focal psychodynamic therapy for EDs	Dietitian to provide letter of treatment to GP at EDP completion InsideOut treatment services database	Other team member Profession: Name: Phone:
Actions for patient to take: <input type="checkbox"/> Use of the Healthy Mind Platter <input type="checkbox"/> Read through RAVES approach <input checked="" type="checkbox"/> Build my treatment team <input type="checkbox"/> Engage family/Friends <input type="checkbox"/> Limit my exercise to set amount <input checked="" type="checkbox"/> Attend all appointments with dietitian/psychologist <input type="checkbox"/> Use Plate by Plate		
Other actions identified by patient:		
Patient education given <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify:		
Copy of EDP offered to patient <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
GP management - frequency of review <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input checked="" type="checkbox"/> As indicated		
GP REVIEW REQUIREMENTS		
Mental health: Prior or at sessions 10, 20 & 30 of psychological treatment & at EDP completion		
Dietetics: At EDP completion		
Note: PSYCHIATRIC OR PAEDIATRIC REVIEW Required in addition to GP review to access sessions 21-40. Consider referring early in course of treatment.		

Patient education given ☐ Yes ☒ No Specify:

Copy of EDP offered to patient ☒ Yes ☐ No

GP management - frequency of review ☐ Weekly ☐ Monthly ☒ As indicated

GP REVIEW REQUIREMENTS

Mental health: Prior or at sessions 10, 20 & 30 of psychological treatment & at EDP completion

Dietetics: At EDP completion

Note: PSYCHIATRIC OR PAEDIATRIC REVIEW

Required in addition to GP review to access sessions 21-40. Consider referring early in course of treatment.

RECORD OF PATIENT CONSENT

I, Darcy Deligiannoudis

(patient name - please print clearly)

agree to information about my mental and medical health to be shared between the GP and the health professionals to whom I am referred, either via correspondence, verbal communication, or case conferences to assist in the management of my health care.

Signature (patient)

Date 25/07/25

I (GP) have discussed the proposed referral(s) with the patient and am satisfied that the patient understands the proposed uses and disclosures and has provided their informed consent to these.

GP Signature

GP Name

Date 25/7/25