the WHOLEBEING co.

HEALTH PROFESSIONAL REFERRAL FORM

Thank you for referring to The Wholebeing Co. Please complete the information relevant to your patient. If you're unsure which dietitian would be the best fit, you can refer to the practice generally and our team will help your patient find an appropriate clinician.

GENTLE NUTRITION specialist

PATIENT DETAILS

- FULL NAME:
- DATE OF BIRTH:
- PRONOUNS (IF KNOWN):
- CONTACT NUMBER:
- EMAIL ADDRESS:
- PARENT / CARER NAME (IF APPLICABLE):
- PARENT / CARER CONTACTDETAILS:

PLEASE SELECT ALL THAT APPLY:

- ☐ eating disorder / eating disorder recovery
- ☐ Disordered eating
- ☐ ARFID / sensory differences with food
- ☐ Relationship with food / body image
- ☐ Intuitive eating
- ☐ Neuroaffirming care
- ☐ Gut health / IBS / digestive symptoms
- ☐ Coeliac disease / IBD
- ☐ Endometriosis / pelvic pain
- ☐ Other:
- ☐ PMOS / PCOS
- ☐ Fertility nutrition
- ☐ Pregnancy / postpartum nutrition
- ☐ Perimenopause / menopause
- ☐ Diabetes / prediabetes
- ☐ Cardiovascular / cholesterol / blood pressure
- ☐ GLP1 nutrition support
- ☐ Sports / performance nutrition
- ☐ General nutrition

- REASON FOR REFERRAL / PRESENTING CONCERNS:

- RELEVANT DIAGNOSES / MEDICAL AND MENTAL HEALTH HISTORY:

- RELEVANT MEDICATIONS:

- RELEVANT PATHOLOGY, INVESTIGATIONS OR CLINICAL INFORMATION:

REFERRAL PATHWAY

- [ ] Private referral
- [ ] GP chronic condition management plan
- [ ] Eating disorder treatment and management plan
- [ ] Other:

- NUMBER OF DIETETIC SESSIONS REFERRED:

- ANY OTHER PREFERENCES OR CONSIDERATIONS?

- ARE THERE ANY COMMMUNICATION, ACCESSIBILITY, SENSORY, NEURODIVERGENCE OR OTHER SUPPORT NEEDS YOU WOULD LIKE US TO BE AWARE OF?

EATING DISORDER REFERRALS

- EATING DISORDER DIAGNOSIS / SUSPECTED DIAGNOSIS:

- CURRENT MEDICAL STABILITY / RELEVANT MEDICAL CONCERNS:

DIETITIAN PREFERENCE

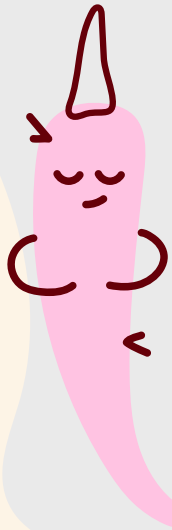
- [ ] No preference - please help the patient find an appropriate dietitian
- [ ] Specific dietitian requested:

APPOINTMENT PREFERENCE

- [ ] In person - Collingwood
- [ ] Telehealth
- [ ] Either

EATING DISORDER TREATMENT AND MANAGEMENT PLAN:

- [ ] Yes - attached
- [ ] Yes - to be forwarded
- [ ] No
- [ ] Not applicable



CURRENT TREATING TEAM

- GP:
- PSYCHOLOGIST / MENTAL HEALTH CLINICIAN:
- PSYCHIATRIST:
- OTHER SPECIALISTS / ALLIED HEALTH PROFESSIONALS:

REFERRER DETAILS

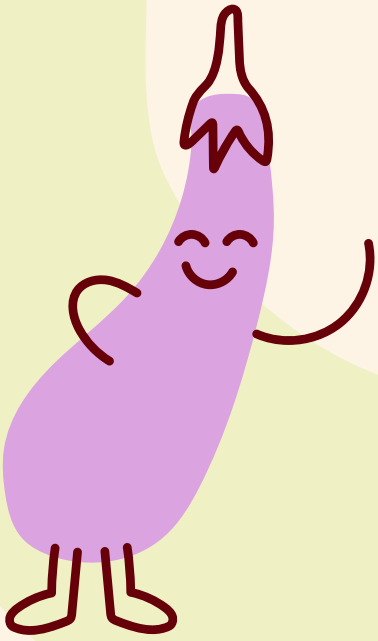
- REFERRER NAME:
- PROFESSION / PROVIDER TYPE:
- PRACTICE / ORGANISATION:
- PROVIDER NUMBER (IF APPLICABLE):
- PHONE:
- EMAIL:
- FAX:

PREFERRED COMMUNICATION:

- [ ] Email
- [ ] Phone
- [ ] Fax

REFERRER SIGNATURE:

DATE:



SEND YOUR REFERRAL TO:

The Wholebeing Co
6/51 Langridge Street
Collingwood VIC 3066

Email: hello@thewholebeingco.com
Phone: 03 9087 3553
Fax: 03 9960 7587

If you're unsure whether The Wholebeing Co is the right service for your patient, please contact our team to discuss the referral.