GP EATING DISORDER PLAN (EDP)

Item No : 90250 - 90257

GP DETAILS					
GP Name Provider No.	Dr Camilla Vorlander 4597107K		Practice Name & address	Yarra Medical Shop 25/313 Victoria Street Abbotsford 3067	
Practice postcode	3067	Practice phone	0390276262	Practice fax	0394213514
GP or practice email					
GP preferred method/s of multidisciplinary team communication	Letter				

PATIENT DETAILS			
First Name	Lejla	Last Name	Kebic
Date of Birth	02/12/1988	Age	36 yrs
Marital Status	Single		
Current Gender Identity	Female		
Address	208/10 Lilydale Grove Hawthorn 3122		
Suburb	Hawthorn	Postcode	3122
Phone (h)		Phone (m)	0490 480 531
Country of Birth	Bosnia	Cultural Identity	Australian
Aboriginal or Torres Strait Islander	Australian		
Main language spoken at home	English		
Proficiency in spoken English	Very well		
Family/ support person details Consider involving support person in session if appropriate	Charles Marshall (Partner) 0406 566 640		

ELIGIBILITY FOR EDP	
EATING DISORDER DIAGNOSIS (DSM-V)	Binge Eating Disorder (BED) - must meet all other criteria
EDE-Q Global Score *(score ≥ 3 for eligibility)*	**4.91**
EATING DISORDER BEHAVIOURS *(at least 1 for EDP eligibility)*	*Binge eating (frequency ? 3 times/ week), Inappropriate compensatory behaviour (e.g. purging, excessive exercise, laxative abuse) (frequency: ? 3 times/week)* Would compensate by skipping meals 7 days a week
CLINICAL INDICATORS *(at least 2 for EDP eligibility)*	☐ *Detail:*
	☐ *Detail:*
	☑ *Detail any psychological/ medical comorbidities and impact on health/ function:* Struggling with body image. Has increased anxiety over her weight as cholesterol levels are high and is trying to bring this down
	☐
	☑ *Details:*
EDP ELIGIBILITY CRITERIA MET	Yes If NO *(consider Better Access to mental health plan)*

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 Mind Body Well Suite 103, 34 Queens Road Melbourne 3000 Phone: 03 9820 1848 Fax: 03 9866 5273	Referred to: Louise Grech Level 1, 134/136 Cambridge St Collingwood. 3066 Phone: 9087 8379 Fax: 9445 9261	Referred to:
Goals: To improve social anxiety and intimacy issues Wanting to discuss prior trauma history	Goals: To improve relationship with food Improve cholesterol levels Improving bowel habits	
Psychological treatments allowed under EDP (to be determined by MH professional): – Family based treatment – Adolescent focused therapy – CBT – CBT-AN – CBT- BN/BED – SSCM for AN – MANTRA for AN – IPT for BN or BED – DBT for BN or BED – Focal psychodynamic therapy for EDs		

Actions record the actions the patient needs to make
To follow up with psychologist and dietician

Emergency Care/Relapse Prevention
GP, Lifeline

Physical examination conducted (see attached)	Yes
Patient education given	Yes
Copy of EDP given to patient	Yes
Copy of EDP given to other providers	Yes

GP REVIEW REQUIREMENTS

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

☐ Dietetics: after Session 1 or 2 and 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

MENTAL HEALTH ASSESSMENT & HISTORY	
Previous specialist mental health care	Saw psychologist that helped her around anxiety however was dismissive about relationship with food.
Family History of Mental Illness	**Mother:** Alive **Father:** Alive **Other family members:** Father PTSD Mother Depression and anxiety
Social history	**Occupation:** Landscape architect **Marital status:** Partnered **Lives with:** partner **Alcohol:** 3 drinks/day 1 days per week. Previously light **Smoking:** Non smoker
Personal History	(eg childhood, education, relationship history, coping with previous stressors) Had escaped from war as a child and has trauma with this.Would use food as a coping mechanism for negative and positive feelings.

Mental Status Examination	
Appearance and General Behaviour Normal Other:	**Mood** (Depressed/Labile) Low Other:
Thinking (Content/Rate/Disturbances) Normal Other:	**Affect** (Flat/blunted) Flat Other:
Perception (Hallucinations etc.) Normal Other:	**Sleep** (Initial Insomnia/Early Morning Wakening) Fluctuates Other:
Cognition (Level of Consciousness/Delirium/Intelligence) Normal	**Appetite** (Disturbed Eating Patterns) Normal
Attention/Concentration Struggles to concentrate at work and with reading. Struggles with staying on task	**Motivation/Energy** Normal
Memory (Short and Long Term) **Struggling with both short and long term memory**	**Judgement** (Ability to make rational decisions) Normal
Insight	**Anxiety Symptoms** (Physical & Emotional)

Normal	**Has a weird feeling in her chest, hands are sweaty, heart racing**
Orientation (Time/Place/Person) Normal	**Speech** (Volume/Rate/Content) Normal

Risk Assessment

Suicidal ideation	☐ YES	☒ NO	Suicidal intent	☐ YES	☒ NO
Current plan	☐ YES	☒ NO	Risk to others.	☐ YES	☒ NO

RECORD OF PATIENT CONSENT

I, **Ms Lejla Kebic**, (**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, to assist in the management of my health care.

	11/07/2025
Signature (patient):	**Date:**

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.

	Dr Camilla Vorlander	**11/07/2025**
GP Signature	**GP Name**	**Date**

EATING DISORDERS PATIENT PHYSICAL ASSESSMENT	
SUGGESTED INITIAL PHYSICAL ASSESSMENT	Height, weight, body mass index (BMI; adults), BMI percentile for age (children) Pulse and blood pressure, with postural measurements Temperature Assessment of breathing and breath (eg ketosis) Examination of periphery for circulation and oedema Assessment of skin colour (eg anaemia, hypercarotenaemia, cyanosis) Hydration state (eg moisture of mucosal membranes, tissue turgor) Examination of head and neck (eg parotid swelling, dental enamel erosion, gingivitis, conjunctival injection) Examination of skin, hair and nails (eg dry skin, brittle nails, lanugo, dorsal finger callouses [Russell's sign]) Sit-up or squat test (ie a test of muscle power)
USEFUL LABORATORY INVESTIGATIONS	Full blood count Urea and electrolytes, creatinine Liver function tests Blood glucose Urinalysis Electrocardiography Iron studies B12, folate Calcium, magnesium, phosphate Hormonal testing – thyroid function tests, follicle stimulating hormone, luteinising hormone, oestradiol, prolactin Plain X-rays – useful for identification of bone age in cases of delayed growth Bone densitometry – relevant after 9–12 months of the disease or of amenorrhoea and as a baseline in adolescents. The recommendation is for two-yearly scans thereafter while the DEXA scans are abnormal.