Te Whatu Ora
Health New Zealand
Te Toka Tumai Auckland

KARI CENTRE
Greenlane Clinical Centre
Private Bag 92 189
Auckland 1142
Ph: (09) 623 4646
kcintake@adhb.govt.nz

Dr:
Practice Name:

Date:

Dear Dr

Re: Client Name:
NHI:

We have recently received a referral for the above young person regarding eating difficulties. We are currently in the process of triaging the referral with the view to completing a mental health assessment.

We thank you for retaining clinical responsibility for this client and would appreciate your completion of our medical form, paying particular attention to the blood pressure and heart rate lying and standing, weight history and bloods**.**

The form identifies clear guidelines around when to consider hospital admission and if concerned, please contact on-call paediatrician/physician to discuss. Please address any urgent issues in your clinic and then send a copy of the completed form to kcintake@adhb.govt.nz in order to inform our triage process.

We appreciate your on-going monitoring of your patient and would encourage the family to seek medical assistance if their young person experiences continued weight loss, dizziness, fainting, palpitations (pounding heart), chest pain or shortness of breath.

We will contact you once we have completed our mental health assessment however please do not hesitate to contact us if you have any questions or concerns.

Yours sincerely,

Kari Acute Focused Team Clinician
Kari Centre (ADHB Child & Adolescent Mental Health Service)

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Initial Medical Monitoring Form

(Please copy to keep this template for ongoing use as needed)

PATIENT NAME:	**NHI:**
Date of examination:	**d.o.b.:**
Examination and form completed by:	

Current Vital Signs:	**Lying** (not sitting)	**Standing** (wait 2 mins between lying and standing)	**Discuss hospital admission with**	
			Starship for <17yo if	**ACH for >17yo if:**
Blood Pressure	/	/	Systolic BP < 80 mmHg or postural drop > 20mmHg	Systolic BP < 80 mmHg or postural drop: > 20 mmHg
Heart Rate			<50 bpm or postural rise by >40 bpm	<40bpm during day time or postural rise by >20bpm
Temperature			<35 C	
Hydration (e.g. capillary refill, JVP, tissue turgor)				
Muscle Strength Test - The sit up, squat, stand test (SUSS).				
Skin colour (e.g. peripheral cyanosis, jaundice)				

Weight & Height: (Please ensure the patient is weighed without wearing any heavy clothing or footwear)

Current Height: Current Weight: BMI:

Weight History:

Highest Weight (when):		**Discuss hospital admission with**	
		Starship for <17yo if:	**ACH for >17yo if:**
Amount of weight lost (maximum and minimum weight with dates over last 3 months if known)		Total body weight < 75% expected (for height) or Acute weight loss of 15-20% in 3 months	Total body weight < 70% of ideal body weight, i.e. BMI < 13 Acute weight loss of 20% in 3 months, in the setting of severe nutritional restriction

Menstruation:

☐ Pre-pubescent ☐ Menstruation (since age)_____ ☐ Amenorrhoea (since age)_____

Weight at which periods ceased, if known_____kg

Is the client currently on contraceptive medication? ☐ Yes ☐ No

Physical Signs and Symptoms & current blood tests:

☐ Syncope ☐ Abdominal pain ☐ Constipation ☐ Palpitations ☐ Fatigue
☐ Dizziness ☐ Weakness ☐ Cold intolerance ☐ Chest pain ☐ Shortness of breath

Please consider if ECG is indicated based on clinical signs and symptoms

AT LEAST FOR BASELINE, PLEASE REQUEST:

Full Blood Count	Renal (K+, Na+, Creatinine, Urea)	B12, Folate
LH, FSH, Oestradiol	Iron Studies, Ferritin	Bicarbonate
TSH, T3, T4	LFTs, Protein, Albumin	Calcium/Magnesium/Phosphate
Glucose (fasting)	**Please consider if admission is needed due to electrolyte imbalance**	