



Do you have experience in treating people with eating disorders?

**Join the Eating Disorders Victoria Private Practitioner database.**

**For Victorian based Health Professionals only.**

Dear Health Professional,

An important and much requested service is the provision of referral options for people seeking treatment from private health practitioners, experienced in treating people affected by eating disorders.

EDV has an in house database of clinical health professionals including GP's, Physician, Pediatricians, Psychologists, Psychiatrists, Psychotherapists, Counselors, Dietitians, Social Workers, Family Therapists and Dentists.

If you work in this area as you may be interested in having your details included on our listing.

As a means of increasing referral options, we encourage you to pass on the details of any other health practitioner you think may have an interest in working with individuals affected by eating disorders. Please know that these practitioners will not be included on the referral list without their full knowledge and consent. Alternatively, please don't hesitate to forward our details on and invite them to contact us.

If you would like to be included on the private practitioner referral database please fill out the application form below. You will be notified of the outcome of your application within 4 weeks.

For further information or queries please contact the EDV Information Officer, Marilyn Amendola on 9885 6563 ext 804 or email: [marilyn.amendola@eatingdisorders.org.au](mailto:marilyn.amendola@eatingdisorders.org.au).

Kind regards,

Marilyn Amendola  
Volunteer Services Coordinator/Information Officer

## Private Practitioner database application form 2011

This form will allow us to update our private practitioner database and provide service users with up to date referral information.

Please advise us of current service listing details, any other information you would like included, and include current practice brochures &/or business cards if available (for record keeping purposes only).

### SERVICE LISTING DETAILS:

Name: \_\_\_\_\_

Date:        /        /

Gender:         Male         Female

Practitioner type:         GP                       Pediatrician                       Physician  
                                  Psychiatrist                       Family Therapist                       Social Worker  
                                  Psychologist (clinical / counseling / health / supervisor/ other \_\_\_\_\_)  
                                  Psychotherapist         Counselor                       Dietitian  
                                  Dentist

Phone (        ) \_\_\_\_\_ Fax (        ) \_\_\_\_\_

Mobile \_\_\_\_\_

Email \_\_\_\_\_

Do you wish to receive email updates regarding EDV events and workshops, changes in treatment information...etc ?         Yes         No

Website (if applicable): \_\_\_\_\_

Are you registered with a relevant association?         Yes         No

If so, with whom? \_\_\_\_\_

- See also memberships in professional organizations section

Please provide your current registration No: \_\_\_\_\_

Have you been police record checked:                       Yes         No *If yes then please provide us with a copy*

Do you have a working with children check?                       Yes         No *If yes then please provide us with a copy*

Have you ever been censured by any professional licensing body?                       Yes                       No

**Postal Address:**

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**Practice details:**

**Please provide details of all practice locations (if different from postal address)**

1. Name of practice \_\_\_\_\_

Practice Address \_\_\_\_\_

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Practice hours \_\_\_\_\_

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Practice contact details: \_\_\_\_\_

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2. Name of practice \_\_\_\_\_

Practice Address \_\_\_\_\_

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Practice hours \_\_\_\_\_

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Practice contact details: \_\_\_\_\_

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3. Name of practice \_\_\_\_\_

Practice Address \_\_\_\_\_

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Practice hours \_\_\_\_\_

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Practice contact details: \_\_\_\_\_

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**Do you provide home visits?**       Yes    No

Notes : \_\_\_\_\_

**Do you provide internet counseling /consultations?**       Yes    No

Notes: \_\_\_\_\_

**FEES**

Cost of initial consultation \_\_\_\_\_

Cost of subsequent consultations \_\_\_\_\_

Are you registered for private health care rebates?       Yes (please specify below)       No

Are you registered for a Medicare rebate?       Yes       No

Are your service fees negotiable/ variable?       Yes       No

Do you bulk bill?       Yes       No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**QUALIFICATIONS** *(Please list relevant degrees, certifications and other training)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEMBERSHIPS IN PROFESSIONAL ORGANISATIONS**

- Australian Health Practitioner Regulation Agency (AHPRA)
- Dental Board of Australia
- Medical Board of Australia
- Nursing and Midwifery Board of Australia
- Psychology Board of Australia
- Australian Psychological Society (APS)
- Australian Counseling Association
- Dietitians Association of Australia (DAA)
- Victorian Association of Family Therapy
- Australian Association of Social Work (AASW)
- Royal Australian & New Zealand College of Psychiatrists (RANZCP)

**Other:**

\_\_\_\_\_  
\_\_\_\_\_

## EXPERIENCE

Years of practice: \_\_\_\_\_

Years of experience working within the field of Eating Disorders \_\_\_\_\_

Could you please list your professional development relevant to eating disorders in the last 5 years?

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## TREATMENT MODALITY/ THERAPY STYLE

How would you characterise your approach to working with people who have an Eating Disorder?

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Please tick which types of Therapeutic approaches you use?

- |  |   |
|--|---|
| <input type="checkbox"/> Cognitive Behavioural Therapy (CBT) | <input type="checkbox"/> Dialectical Behavioural Therapy (DBT)    |
| <input type="checkbox"/> Interpersonal Therapy (IPT)         | <input type="checkbox"/> Family Therapy                           |
| <input type="checkbox"/> Gestalt Therapy                     | <input type="checkbox"/> Maudsley Method / Family Based Treatment |
| <input type="checkbox"/> Psychodynamic Therapy               | <input type="checkbox"/> Strengths Based                          |
| <input type="checkbox"/> Solution Focused                    | <input type="checkbox"/> Acceptance and Commitment Therapy /ACT   |
| <input type="checkbox"/> Systemic                            | <input type="checkbox"/> Other _____                              |
| <input type="checkbox"/> Psychoanalysis                      |   |

Which types of eating disorders/disordered eating do you have experience/specialise in dealing with?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Anorexia Nervosa                                 | <input type="checkbox"/> Bulimia Nervosa   | <input type="checkbox"/> Binge Eating Disorder |
| <input type="checkbox"/> Eating Disorders Not Otherwise Specified (EDNOS) | <input type="checkbox"/> Disordered Eating |  |
| <input type="checkbox"/> Compulsive Eating / Overeating                   | <input type="checkbox"/> Other _____       |  |

Which age group(s) do you specialize in?

- |                                   |                                      |                                 |                                  |
|-----------------------------------|--------------------------------------|---------------------------------|----------------------------------|
| <input type="checkbox"/> Children | <input type="checkbox"/> Adolescents | <input type="checkbox"/> Adults | <input type="checkbox"/> Elderly |
|-----------------------------------|--------------------------------------|---------------------------------|----------------------------------|

Do you work with:  Individuals  Groups  Family  Couples

Do you provide:  Medical assessment  Nutritional assessment  
 Psychological Assessment  Other \_\_\_\_\_

**Other areas of specialty (please tick if you specialise in any of the areas below)**

**Mental Health**

- Attention Deficit Hyperactivity Disorder (ADHD)
- Anxiety, phobias, OCD, panic disorders
- Asperger's Syndrome / Autism
- Bipolar Disorder
- Depression
- Dissociative Identity Disorder
- Gender/sexual Identity Disorder
- Mental Illness
- Personality disorders
- Post natal depression
- Psychosis
- Schizophrenia

**General Health**

- Chronic disease management
- Health related problems
- Infertility issues
- Memory problems
- Rehabilitation / injury counseling
- Relaxation
- Sleep disorders
- Stress management
- Terminal illness
- Weight related issues / obesity
- Body Image

**Trauma/Harm**

- Sexual abuse
- Post Traumatic Stress Disorder (PTSD)
- Psychological First Aid
- Suicide
- Victims of crime
- Bullying
- Cult involvement
- Domestic Violence

**Personal**

- Anger management / Assertiveness training
- Behaviour problems
- Gay/lesbian issues
- Grief & loss
- Life/personal coaching
- Life transition & adjustment issues
- Motivation in sport
- Orphanages / Children's home issues
- Religious issues
- Self-esteem & self development
- Sexual difficulties

**Relationships**

**Addictions**

**Work/community**

**Legal**

*Please note the areas of specialty have been developed from the Australian Psychological Society (APS) website. [www.psychology.org.au](http://www.psychology.org.au)*

Are you fluent in any other language other than English (including ASL for hearing impaired)?

If so please specify \_\_\_\_\_

**OTHER INFORMATION**

Please note information about yourself or your practice that potential clients or referral sources would benefit from knowing.

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**OTHER REFERRAL SOURCES**

Name, position and contact number of any practitioner(s) you think might have an interest in working with people who have an eating disorder.

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**Please sign & date**

**SIGNATURE:** .....

**DATE:**     /     /