| **EARLY ONSET EATING DISORDER (EoED)** | *APSU Office Use Only* | |
|---|---|---|
| Australian Paediatric Surveillance Unit | *Study ID #:* | |
| Please contact the APSU on (02) 9845 3005; SCHN-APSU@health.nsw.gov.au<br>If you have any questions about this form | *Month/Year Report:* | |
| *Instructions: Please answer each question by ticking the appropriate box or writing your response in the space provided. DK=Don't Know; NA = Not Applicable* | *Version 1_19.11.2015* | |

**REPORTING CLINICIAN'S DETAILS**

**1**. APSU Dr Code/Name: __ __ __ __ /_____ **2**. Date questionnaire completed: __ __ / __ __ / __ __ __ __

**PATIENT DEMOGRAPHICS**

**3.** First 2 letters of first name: __ __ **4.** First 2 letters of surname: __ __ **5.** Date of Birth: __ __ / __ __ / __ __

**6.** Sex: ☐ M ☐ F **7.** Postcode of family: __ __ __ __ **8.** Date diagnosed: __ __ / __ __ / __ __

**If this patient is primarily cared for by another physician who you believe will report the case, please complete the questionnaire details above this line and return to APSU. Please keep the patient's name and other details in your records. If no other report is received for this child we will contact you for information requested in the remainder of the questionnaire.**

*The primary clinician caring for this child is:* ***Name:*** ***Hospital:***

**CLINICAL FEATURES**

*Instructions: Please answer each question by placing a tick in the appropriate box or writing your response in the space provided.*

**Please indicate symptoms or signs present at the time of presentation. Please respond to each item**

| | | | | | |
|---|---|---|---|---|---|
| **9.** Food avoidance | ☐ Yes | ☐ No | ☐ DK | | |
| **10.** Excessive exercising | ☐ Yes | ☐ No | ☐ DK | | |
| **11.** Self induced vomiting | ☐ Yes | ☐ No | ☐ DK | | |
| **12.** Fear of weight gain/fatness | ☐ Yes | ☐ No | ☐ DK | | |
| **13.** Perception that body shape/size is larger than it is | ☐ Yes | ☐ No | ☐ DK | | |
| **14.** Preoccupation with body weight | ☐ Yes | ☐ No | ☐ DK | | |
| **15.** Preoccupation with food/ food intake | ☐ Yes | ☐ No | ☐ DK | | |
| **16.** Binge eating | ☐ Yes | ☐ No | ☐ DK | | |
| **17.** Laxative abuse | ☐ Yes | ☐ No | ☐ DK | | |
| **18.** Diuretic abuse | ☐ Yes | ☐ No | ☐ DK | | |
| **19.** Somatic complaints eg. abdominal pain without specific cause | ☐ Yes | ☐ No | ☐ DK | | |
| **20.** Denial of severity of illness | ☐ Yes | ☐ No | ☐ DK | | |
| **21.** Is weight loss/failure to gain weight due to an organic cause? | ☐ Yes | ☐ No | ☐ DK | | |
| **22.** Has the child reached menarche? | ☐ Yes | ☐ No | ☐ DK | ☐ Not applicable | |
| **23.** ***IF YES to 22***, is there now secondary amenorrhoea? | ☐ Yes | ☐ No | ☐ DK | ☐ Not applicable | |

**24.** Current weight ……kg ……..centile ☐ DK

**25.** Current height……..cm ……centile ☐ DK

**26.** Change in weight over previous 6 months:

- ☐ no change
- ☐ decreased (if known, specify decrease in kg ……)
- ☐ increased (if known, specify increase in kg ……)
- ☐ DK

**27.** Change in height over previous 6 months

- ☐ no change
- ☐ increased (if known, specify increase in cm ……)
- ☐ DK

**28.** Maximum weight ever recorded ……kg ……centile ☐ DK

**29.** Date when maximum weight was recorded (year & month)……

**30.** Pubertal Status: *Tanner Stage*

**a.** Breast development: ☐ Stage 1 ☐ Stage 2 ☐ Stage 3 ☐ Stage 4 ☐ Stage 5 ☐ DK ☐ Not applicable

**b.** Pubic Hair: ☐ Stage 1 ☐ Stage 2 ☐ Stage 3 ☐ Stage 4 ☐ Stage 5 ☐ DK

**31.** What was the duration of symptoms prior to diagnosis?……..weeks or ……months ☐ DK

**EXAMINATION FINDINGS**

Please indicate if any of the following were detected.

**32.** Temperature <35.5°C ☐ Yes ☐ No ☐ DK

**33**. Hypotension (systolic BP <80) ☐ Yes ☐ No ☐ DK

**34.** Bradycardia (<50 beats/min) ☐ Yes ☐ No ☐ DK IF YES, lowest recorded rate……

**PSYCHIATRIC ILLNESS**

Did the child have a concurrent psychiatric illness?

**35.** Depression ☐ Yes ☐ No ☐ DK

**36.** Obsessive compulsive disorder ☐ Yes ☐ No ☐ DK

**37.** Anxiety ☐ Yes ☐ No ☐ DK

**38.** Any other psychiatric illness (please specify)……

……

**39.** Is there a family history of psychiatric illness (including anorexia nervosa)? ☐ Yes ☐ No ☐ DK

**40.** ***IF YES to 39***, please give diagnosis and relationship to child……

……

**MANAGEMENT**

**41.** Was the child admitted to hospital? ☐ Yes ☐ No ☐ DK

**42.** ***IF YES to 41***, please indicate the type of hospital to which the child was admitted:

**a.** Metropolitan general hospital ☐ Yes ☐ No ☐ DK

**b.** Rural community hospital ☐ Yes ☐ No ☐ DK

**c.** Paediatric teaching hospital ☐ Yes ☐ No ☐ DK

**d.** General psychiatric hospital ☐ Yes ☐ No ☐ DK

**e.** Child & Adolescent Psychiatric Unit ☐ Yes ☐ No ☐ DK

**43.** If the child has already been discharged, what was the total duration of hospital admission?……..days

**44.** If the child has not been discharged, what is the total duration of admission to date? ……days

**45**. Did the child receive naso-gastric tube feeding? ☐ Yes ☐ No ☐ DK

**46.** Were psychotropic medications prescribed for concurrent psychiatric illness? ☐ Yes ☐ No ☐ DK

**47.** ***IF YES to 46***, specify psychotropic medication(s) ……

**48.** At the time of your last contact with the family was the child alive? ☐ Yes ☐ No ☐ DK

**49.** ***IF YES to 48,*** in your opinion was the patient's condition ☐ improved ☐ unchanged ☐ worse ☐ DK

**PHYSICAL EXAMINATION FINDINGS AT DIAGNOSIS**

Please indicate which of the following health professionals have been **<u>required</u>** in the patient's care.

**50.** Paediatrician ☐ Yes ☐ No ☐ DK

**51.** Psychiatrist ☐ Yes ☐ No ☐ DK

**52.** Dietitian ☐ Yes ☐ No ☐ DK

**53**. Psychologist ☐ Yes ☐ No ☐ DK

**54.** Specialist eating disorder unit ☐ Yes ☐ No ☐ DK

**55**. Other (please specify). ……

**HISTORY**

**56.** Is there a history of food allergy ☐ Yes ☐ No ☐ DK

***IF YES*** please specify……

……

**57.** Does this child have a history of significant feeding difficulties in early life ( e.g. fussy eating, referral to a feeding clinic)

☐ Yes ☐ No ☐ DK

***IF YES*** please specify ……

……

***Thank you for your help with this research project. Please return this questionnaire to the APSU by fax to 02 9845 3082. Australian Paediatric Surveillance Unit, Kid's Research Institute, Locked Bag 4001, Westmead NSW 2145.***

The Australian Paediatric Surveillance Unit is affiliated with the Royal Australasian College of Physicians (Paediatrics and Child Health Division) and Sydney Medical School, The University of Sydney. APSU is funded by the Australian Government Department of Health and Ageing. This study has been approved by a Human Research Ethics Committee properly constituted under NHMRC guidelines.