

Recovery Resources



REFERRAL DIRECTORY INCLUSION



Practice Name if Applicable:

Practice Ph:

Tick if able to display/give to clients

Practice Street Address:

Postal Address:

Email:

Tick if able to display/give to clients

Website:

Practitioner(s) Names, profession and qualification:

Professional body/association(s) that I am a member of:

Which Eating Disorders do you specialise in?

(Select all relevant)

- All
- Anorexia
- Bulimia
- Binge Eating
- Other Specified Feeding and Eating Disorders
- Other _____

Discipline (Select all relevant)

- Psychology
- Psychiatry
- General Practice
- Dietetics/Nutrition
- Counsellor/Therapist
- Multidisciplinary Team
- Other _____

Target Group (Select all relevant)

- Children <13
- Adolescents <18
- Adults >18
- Older Adults >50
- Females
- Males
- Transgender
- Carers
- Families
- All
- Other _____

Fee Structure (Select all relevant)

- Private Medical Insurance Rebate
- Bulk Billing/Public/Free
- Medicare Rebate/Mental Health Provider
- ATAPS Provider
- Other _____

How would you rate your professional knowledge of/ experience with eating disorders?

Average Good Excellent New to Field

Do you have Public Liability and Professional Indemnity Insurance?

Yes No

Please email your completed form to:
or mail to:

sarah@recoveryresources.com.au

Sarah-Louise McKenzie

c/o P.O. Box 249,

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