Essex Community Adult Eating Disorder Service

Referral Form

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| **Information Required for Referral Form** |
| To ensure that referrals are dealt with promptly and triaged appropriately for urgency of the patient’s needs, we ask you to complete the following referral form containing the following information. Physical health information (including weight, height and pattern of weight loss) is essential information needed for us to triage a referral. Lack of appropriate information may lead to the referral not being accepted.  Until the CAEDS assessment of your patient is completed and a treatment plan has been agreed, you remain responsible for your patient’s care.  If any Moderate or High Risks are indicated in your assessment please follow the NICE guidelines regarding Risk Management. |

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| **Section 1** |

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| **Patient Demographics** | | | | | |
| First Name: |  | | | Surname: |  |
| Mobius/Paris Number: | |  | | NHS Number: |  |
| Address: | | | | DOB: |  |
| Email: |  |
| Landline: |  |
| Mobile: |  |
| Has the patient been treated previously for an eating disorder? ☐ Yes ☐ No | | | | | |
| Duration of current Eating Disorder: | | | | | |
| Disability: (*please tick if appropriate*) | | | | | |
| ☐ Visual | ☐ Speech | ☐ Learning | ☐ Mobility | ☐ None | ☐ Other: |
| Ethnicity: | | | | | |

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| **GP Information** | | | |
| GP Name: |  | GP Practice: |  |
| E-mail: |  | Telephone: |  |
| Address: |  | | |

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| **Referrer Details** | | | |
| Name: |  | Job Title: |  |
| Referring Service: |  | If other, please state: |  |
| Telephone: |  | E-mail: |  |
| Address: |  | | |
| Date of Referral: |  | | |

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| **Care Co-ordinator -** Please complete if appropriate | | | |
| Name: |  | E-mail: |  |
| Address: |  | Telephone: |  |

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| **Carer Details –** Please complete if appropriate | | | |
| Name: |  | | |
| Relationship: |  | Address: |  |
| Telephone: |  | Landline: |  |

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| **Other Professionals Involved** | | | |
| Name: |  | E-mail: |  |
| Address: |  | Telephone: |  |

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| **Physical Health Assessment** | | | |
| Height: |  | Date: |  |
| Weight: |  | Date: |  |
| BMI: |  | Date: |  |
| Does the patient have type 1 diabetes ☐ Yes ☐ No | | Is the patient pregnant ☐ Yes ☐ No | |

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| **BMI is a proxy measure of risk.**  To further determine risk please place a cross in those areas that are relevant | | | | | |
| Abnormal bloods | ☐ | Details: |  | Date of test: |  |
| Abnormal vitals including ECG | ☐ | Details: |  | Date of test: |  |
| Rate of weight loss | ☐ | Total amount of weight loss since onset of symptoms:  kg | | | |
| Rapid loss >0.5kg/week | ☐ |

Note: Please see below for sections 2 and 3.

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| **Section 2** |

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| **Reason for Referral** | | | | |
| Missing meals | ☐ Yes ☐ No | Details: |  |  |
| Restricting meals? | ☐ Yes ☐ No | Details: |  | |
| Binge eating | ☐ Yes ☐ No | Frequency per day/week: | |  |
| Self-induced vomiting | ☐ Yes ☐ No | Frequency per day/week: | |  |
| Excessive exercise | ☐ Yes ☐ No | Frequency per day/week: | |  |
| Laxative misuse | ☐ Yes ☐ No | Frequency per day/week: | |  |
| Diuretics / diet pills | ☐ Yes ☐ No | Frequency per day/week: | |  |
| Other, please specify: | | | | |

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| **Brief history of Eating Difficulties** |
| Brief overview of Eating Disorder cognitions (e.g., reasons for weight loss or dietary restriction and other ED behaviours, sensory difficulties around food, etc.): |
| Additional information: |

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| **Physical Health / Medical Conditions** |
| Have other physical health complications been considered and/or investigated, or currently being carried out? If so, please explain: |
| Any additional concerns? Please include current/historic mental health diagnoses/difficulties (e.g., mood disorder, bipolar disorder, substance misuse): |
| Current or past RISK to self or others (including history of self-harm, safeguarding issues, etc.)  Please give full details: |

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| **Current Medications** |
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| **Section 3** |

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| **Patient Views Regarding Referral**  Is patient in agreement with referral to Eating Disorders Services? |
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| **Other Information:**  (Please attach any other relevant reports/information which may be helpful in the assessment) |
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