BEDFORDSHIRE & LUTON ADULT COMMUNITY EATING DISORDERS SERVICE

PAPER REFERRAL FORM

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| To evaluate the priority of the referral we have included a number of **mandatory fields** in this form. As we are operating an opt-in/waiting list system this information helps us determining the current risk and allows us to offer input more quickly where required. |

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| **Reason For Referral** |
| The Bedfordshire and Luton Adult Community Eating Disorders Service offers outpatient psychological therapy for eating disorders within an MDT with adjunct dietetic and psychiatric advice.  We also facilitate admission to national Specialist inpatient Eating Disorder Units (SEDUs) when indicated.  For this referral, please indicate which of the following you and your patient are seeking:[ ]  The patient is aware of the referral and consents because:[ ]  The patient wishes to be assessed for outpatient psychological therapy focused on recovery from their eating disorder.[ ]  We think the patient needs assessment for referral to a Specialist Eating Disorder Unit for inpatient treatment.[ ]  We are not sure whether they have an eating disorder/what support is recommended so we would like a specialist assessment report with recommendations.[ ]  I would like specialist advice or consultation from the MDT. The question/issue I am looking for advice on is:

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| **Patient Information** |
| Gender: [ ]  Female [ ]  Male | Current Weight: Height: BMI: Click or tap here to enter text.Weight History: Please state whether weights are objectively verified or self-reported. |
| Name:  |
| Address:  |
| NHS Number:  |
| DOB (must be 18+):  | Age:  |
| Ethnicity:  |
| Telephone:  |
| Email:  |

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| **Referrer Information** |
| Name:  | Designation:  |
| Address:  | Date of Referral:  |
| Telephone:  | Email:  |
| **GP Information** |
| Name:  | Address:  |
| Telephone:  | Email:  |

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| **Eating Disorder Symptoms in the *Last Month*** |
| Food Restriction | [ ]  Yes [ ]  No | Weekly Frequency: | Details:  |
| Binge Eating*Eating an unusually large amount of food in a short period of time (<2 hours), with a sense of lack of control (cannot stop or control what or how much) and marked distress.* | [ ]  Yes [ ]  No | Weekly Frequency:  | Details:  |
| Induced Vomiting | [ ]  Yes [ ]  No | Weekly Frequency:  | Details:  |
| Laxative Misuse | [ ]  Yes [ ]  No | Weekly Frequency:  | Details:  |
| Diet/Slimming Pills or Diuretics | [ ]  Yes [ ]  No | Weekly Frequency:  | Details:  |
| Excessive Exercise | [ ]  Yes [ ]  No | Weekly Frequency:  | Details:  |
| Drugs/Alcohol Misuse | [ ]  Yes [ ]  No | Weekly Frequency:  | Details:  |
| Insulin Misuse | [ ]  Yes [ ]  No | Weekly Frequency:  | Details:  |
| Duration of Current Episode:  |
| **Background Information:** Please summarise below or attach referral letter outlining other relevant information such how the problem developed, body image issues, eating disorder thinking, significant weight, or significant social or family circumstances. |
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| **Medical Information** (Please note that this information helps us to prioritise the referral and advise you, but we do not assume medical responsibility.) |
| Eating Disorder History/ Previous Treatment: |
| Current Psychiatric Diagnoses/ Treatment: |
| Other Relevant Psychology/Psychiatry History & Interventions (Please attach any relevant reports): |
| Is the patient currently open to a CMHT? (Please provide details and relevant reports):[ ]  Yes [ ]  No |
| Prescribed Medications: |
| Current Physical Health Issues (e.g., diabetes): |
| Please include recent bloods tests within the last MONTH (U&Es, FBC) as per King’s College Guidelines: |
| Please include any recent ECGs and results of any other relevant tests: |
| Any Other Services Involved: |

**Eating Disorders Service**

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