## 

**Referral to Eating Disorders Service at Brownhill Centre, Cheltenham, Gloucestershire**

**PLEASE PROVIDE AS MUCH INFORMATION AS YOU CAN AND ARRANGE ROUTINE BLOOD SCREEN AS BELOW**

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| --- | --- |
| **DATE REFERRAL**  **FORM COMPLETED:** | **TYPE OF REFERRAL:** Self / Parent / GP / Other - please specify |
| **INFORMATION FOR PERSON BEING REFERRED:** | |
| FIRST NAME: | SURNAME: |
| DOB: | AGE: |
| MOBILE: | LANDLINE: |
| ADDRESS: | |
| POSTCODE: | GENDER: |
| NHS NUMBER: | |

**CONSENT:**

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| HAS THE PERSON BEING REFERRED (OR IF THEY ARE BELOW AGE 16, A PARENT) CONSENTED TO THIS REFERRAL? YES / NO |

**GP INFORMATION:**

|  |  |
| --- | --- |
| GP NAME: | GP PHONE NUMBER: |
| GP ADDRESS: | |

**PERSON REFERRING: (If different from above)**

|  |  |
| --- | --- |
| NAME: | PHONE NUMBER: |
| RELATIONSHIP TO REFERRED INCLUDING ORGANISATION IF APPROPRIATE: | |

**SCHOOL/COLLEGE INFORMATION (IF UNDER 18):**

|  |  |
| --- | --- |
| NAME: | PHONE NUMBER: |
| ADDRESS: | |

**PHYSICAL HEALTH:**

|  |  |
| --- | --- |
| CURRENT HEIGHT: | CURRENT WEIGHT: |
| **ROUTINE BLOOD SCREEN TO BE UNDERTAKEN IN PRIMARY CARE AS FOLLOWS:**  **UNDER AGE 18** - full blood count, electrolytes, liver function, renal function, including calcium, phosphate and magnesium, random glucose, iron status, coeliac antibody screen, inflammatory markers (C reactive protein (CRP), erythrocyte sedimentation rate, plasma viscosity), thyroid function.  **AGE 18+** - full blood count, electrolytes, liver function, renal function, including calcium, phosphate and magnesium, iron status, random glucose, inflammatory markers (C reactive protein (CRP), erythrocyte sedimentation rate, plasma viscosity), thyroid function. | |
| DATE LAST BLOODS TAKEN: | |

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| **REASON FOR REFERRAL:** |
| **ADDITIONAL PRESENTING CONCERNS (including general mental health):** |
| **WEIGHT PATTERN (over recent months):** |
| **CURRENT FOOD INTAKE:** |
| **CURRENT FLUID INTAKE:** |

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| |  |  |  | | --- | --- | --- | |  | **Yes/No** | **Frequency per day/week** | | **Missing meals** | Yes  No |  | | **Restricting meals** | Yes  No |  | | **Binge eating** | Yes  No |  | | **Vomiting** | Yes  No |  | | **Laxatives** | Yes  No |  | | **Diuretics / Diet Pills** | Yes  No |  | | **Excessive exercise** | Yes  No |  | | **Substance misuse (specify)** |  |  | |
| **PREVIOUS CONTACT WITH EATING DISORDERS SERVICES :**  Yes  No |
| **PREVIOUS EATING DISORDERS TREATMENT:** |
| **CURRENT LEVEL OF MOTIVATION TOWARDS TREATMENT AND CHANGE:** |

*To be completed by medical professional referrers only*

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| **RISK INDICATORS** (if high risk we advise URGENT referral to the Eating Disorders Service and consideration of referral to A&E. Please feel free to consult with our Risks High in Eating Disorders (RHED) Team 01242 634242)   |  |  | | --- | --- | | High risk factors? | Please tick if appropriate | | BMI <13 (adults) or <70% median BMI for age (under 18)? |  | | Recent loss of ≥1 kg for two consecutive weeks? |  | | Little or no nutrition for >5 days? |  | | Acute food refusal or <500 kcal/day for >2 days in under 18s? |  | | Pulse <40? |  | | BP low with postural dizziness? |  | | Core temperature <35°C? |  | | Na <130 mmol/L? |  | | K <3.0 mmol/L? |  | | Raised transaminase? |  | | Glucose <3 mmol/L? |  | | Raised urea or creatinine? |  | | ECG: e.g. bradycardia? QTc >450 ms? |  | |

**Please send all completed forms to:**

**Fax:** 01242 634284

**Email**: [EatingDisordersServiceReferrals@](mailto:EatingDisordersServiceReferrals@)ghc.nhs.uk

**Post:** The Eating Disorders Service, The Brownhill Centre, St Paul’s Medical Site, 121 Swindon Road, Cheltenham, Gloucestershire, GL51 9EZ