**Derbyshire Eating Disorders Service**

**Unity Mill, Derwent Street, Belper, Derbyshire, DE56 1WN, Telephone: 01773 881467**

**Email completed forms to:** [**dhcft.eatingdisordersservice@nhs.net**](mailto:dhcft.eatingdisordersservice@nhs.net)

**(Please complete this form as fully as possible.**

**We have highlighted information \* which if absent, the referral may not be accepted)**

**Derbyshire Eating Disorders Service is not an emergency service. Refer to MEED for further guidance:** [Medical Emergencies in Eating Disorders (MEED): Guidance on recognition and management (CR233) (rcpsych.ac.uk)](https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2022-college-reports/cr233)

Referral criteria:

* 18 years or older (If <18yrs refer to CAMHS Eating Disorder Service, though in some circumstances a direct referral to our adult service may be appropriate. Please call us to discuss)
* Registered with a Derbyshire GP
* The eating disorder is the primary concern.

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| **Date of referral:** |  | | | | | | | |
| **\***Has the patient consented to this referral? | Yes | | | | No | | | |
| **Referrer Details:** | **GP Details:** | | | | | | | |
| **\***Name, Address & Telephone Number: | Name, Address & Telephone Number: | | | | | | | |
| **\***Is the patient registered elsewhere (e.g., during university holidays?): |  | | | | | | | |
| **Patient Details:** | | | | | | | | |
| **\***Patient name: |  | | | | | | | |
| **\***NHS No: |  | | | | | | | |
| **\***Address: |  | | | | | | | |
| **\***Telephone No: |  | | | | | | | |
| **\***Date of Birth: |  | | | | Age: | | | |
| Does the patient speak English: | Yes | | | | No | | | |
| What is the patients preferred language? |  | | | | | | | |
| **Clinical Information:** | | | | | | | | |
| **\***Weight history (record last 3 documented weights, most recent must be within the last month): | 1. |  | | date: | | |  | |
| 2. |  | | date: | | |  | |
| 3. |  | | date: | | |  | |
| **\***Height (in cm or meters): |  | | | | | | | |
| BMI (weight in kg/height in m²): |  | | | | | | | |
| Is weight now: (please select): | Stable | | Falling | | | | | Increasing |
| Weight change in the last 3- 6 months: | Kg / week | | | | | | | |
| **\***Heart rate: |  | | | | | | | |
| **\***Blood pressure: | Standing: | | | | | Sitting: | | |
| Temperature: |  | | | | | | | |
| **\***Blood tests arranged:  Please arrange the following to exclude the most common undiagnosed somatic reasons for weight loss (e.g., Coeliac disease, chronic inflammatory bowel disease).  **These must be from within the last 3 months.** | FBC; U&E’s; LFTs; TFTs; HbA1c; Calcium; Magnesium; Phosphate; Zinc; Creatinine kinase; B12; Folate; Vitamin D, ESR, CRP, Lipids, anti-tTG antibodies; glucose  Consider ECG if bradycardic, there is a cardiac history or if taking QT interval altering drugs. Include the cardiac trace if possible. | | | | | | | |
| Medications(prescribed and non-  prescribed) / Supplements |  | | | | | | | |

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| **Past Medical History** (including current health conditions e.g., diabetes; coeliac disease; IBD; IBS or other GI conditions; osteoporosis. If diabetic include recent history of severe hypoglycemic episodes, admissions for DKA and recurrent ketonemia >3mmo/l): | |
|  | |
| **Current Eating Disorder Behaviours & Symptoms:** | |
| **\***Restricting dietary intake: | Acute food Refusal (had little or no intake for >2 days)  Choosing low calorie food  Skipping meals (e.g., eating <3 main meals per day)  Eating smaller than average portions  Excluding entire food groups e.g., dairy/carbohydrates/meat/veg/fruit |
| **\***Fluid intake: | Refusing fluids (with reduced urine output)  Restricting fluids  Drinking excessive amount (fluid loading) |
| **\***Vomiting (& frequency): | Multiple daily episodes  ≥3 x per week |
| **\***Using laxatives: | Multiple daily episodes  ≥3 x per week |
| **\***Excessive exercise: | > 2 hours per day  1-2 hours per day  < 1 hour per day |
| **\***Binge eating (larger than typically eaten in an hour): | Yes  No |
| **\***Food avoidance based on any of the following: | Disturbed body image (e.g., believes they are overweight when they are objectively underweight)  Texture of food  Smell of food  Taste of food  Appearance of food  Lack of hunger/appetite/ interest in eating  To help manage negative emotions.  Fear of consequences of eating e.g.   * choking * vomiting * gastrointestinal symptoms * weight gain * Other  (specify): |
| **\***Self-harm: | Yes  No |
| Other behaviours (e.g., insulin restriction/omission): |  |
| **History of eating problems and response to any previous interventions** (include any specific treatments previously or currently being undertaken with the patient and the impact of the eating problems on the person’s mental health): | |
|  | |
| **Previous psychiatric history** (including substance misuse, self-harm, suicidal ideation): | |
|  | |
| **Previous/present contact with mental health services and when:** | |
| IAPT CMHT CAMHS Other Eating Disorders service  First StepsGastroenterology    Pleasesummarise details: | |
| **\*Please highlight any risks (to self or others) for triage:** | |
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