**Referral Form: Wiltshire Community Eating Disorder Service**

To make a referral to the Wiltshire Community Eating Disorder Service please complete this form and email to Cotswold.house@oxfordhealth.nhs.uk

If you would like to discuss a referral, please telephone our service on 01865 904099 and ask to speak with a clinician.

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| **Patient Name** |  | **Date of Birth** |  |
| **NHS No** |  | **Gender** |  |
| **Patient Ethnicity** |  | **Patient Contact Number** |  |
| **Patient Home Address** |  |

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| --- | --- | --- | --- | --- |
| **Referrer Name** |  | **Referrer Contact Number** |  |  |
| **Referrer Address** |  | **GP Surgery Address***(if different to referrer)* |  |  |
| **Type of Referral**\*(Emergency / Urgent/ Routine) |  | **Date of Referral** |  |  |

*\*****Emergency*** *(checked by senior clinician in the same day)* ***Urgent*** *(checked by senior clinician within 2 working days)* ***Routine*** *(discussed in MDT meeting within 5 working days).*

Please note that each referral is triaged and then an assessment appointment is offered within 1 week (emergency), 2 weeks (urgent), or 4 weeks (routine) from when received.

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| --- | --- | --- | --- | --- | --- |
| **Patient Height:** |  | **Patient Weight:** |  | **BMI:** |  |

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| **Please identify which of the following apply for your patient:***(mark ‘Y’ for yes or ‘N’ for no)* |
| **Weight loss**  |  | **Restricting food** |  | **Binge eating** |  | **Self-induced vomiting** |  |
| **Laxative use** |  | **Diet tablets** |  | **Diuretics**  |  | **Excessive exercise** |  |

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| **Reason for referral:***(e.g. details of eating disorder symptoms, detail of extent of any weight loss, what support does the patient want from our service/what do they want to be different)* |
| **Is the patient aware of the referral to our service?** |
| **Has a recent blood test been completed?***(We recommend FBC, U+Es, LFTs and bone profile for patients who have rapidly lost weight or who are underweight, or for patients who are engaging in behaviours such as self-induced vomiting or misuse of laxatives, regardless of weight)**Please specify if any abnormal values such as low K* |
| **Are there any risk concerns?** *(e.g. self-harm, suicidal ideation, substance misuse, or physical health risk)* |
| **Please detail any other mental health diagnoses or input from any other mental health services:** |
| **Please detail any medical conditions or pertinent medical information:***(e.g. diabetes, gastric band, history of surgery)* |
| **Any other information:** |