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**East London Foundation Trust  
Community Disordered Eating Team**  
1st Floor, Burdett House  
Mile End Hospital  
London, E1 4DG

**Telephone: 07827305136**

Please return completed form to: elft.DisorderedEatingSupport@nhs.net

Please attach any recent test results, assessment reports and discharge summaries to your referral.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **These fields are mandatory:** | | | | | | | | |
| **Date of Referral:** | | |  | | | | | |
| **Is this referral urgent?**  *(If yes, please provide details):* | | | **Yes  No** | | | | | |
| **Referrer Details:** | | | | | | | | |
| **Name and Address of Referrer:** | | |  | | | | | |
| **Tel No:** | | |  | | | | | |
| **Fax No:** | | |  | | | | | |
| **Email** (NHS.net if available): | | |  | | | | | |
| **Name & Telephone number of Hospital Ward** (if patient is already admitted): | | |  | | | | | |
| **Demographic Information:** | | | | | | | | |
| **Name of Patient:** | | |  | | | | | |
| **NHS Number:** | | |  | | | **Marital Status:** | |  |
| **Date of Birth:** | | |  | | | | | |
| **Tel Number:** | | |  | | | | | |
| **Address:** | | |  | | | | | |
| **Ethnicity:** | | |  | | | | | |
| **Name and address of GP:** | | |  | | | | | |
| **CCG:** | | |  | | | | | |
| **Interpreter Required?** | | | **Yes  No**  (If yes, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | | | | | |
| **Clinical Information:** | | | | | | | | |
| **BMI:** |  | | | **Recent Rapid Weight Loss?** | | | **Yes  No**  If yes, please specify history of recent rapid weight loss: | |
| **Weight:** |  | | |
| **Height:** |  | | | **Pregnancy?** | | | **Yes  No**  If yes, gestation \_\_\_\_ weeks | |
| **Menstrual History:** |  | | | **Diabetes?** | | | **Yes  No** | |
| **Current Eating Disorder Symptoms:** | | | | | | | | |
| *(Please detail any relevant, including: anorexic thoughts, restriction, binges, compensatory behaviours and details of any recent rapid weight loss in the past six months)* | | | | | | | | |
| **Mental Health Information:** | | | | | | | | |
| **Current Care Team** *(if applicable):* | |  | | | | | | |
| **Care Co-ordinator?** | | **Yes  No**  *(If yes, please provide contact details below):* | | | | | | |
| **Eating Disorder Symptoms:**  \*\*if you tick one of the eating disorder symptoms, please state **frequency** of symptoms as this is required for prioritising.\*\*  **For example:** 3xWeek / 2xDaily. *If occurring daily, please also specify how many times a day* | | Age of Onset: \_\_\_\_\_\_   |  |  |  | | --- | --- | --- | |  |  | **Frequency** | | Food Restriction |  |  | | Fluid Restriction |  |  | | Excessive Fluid |  |  | | Self-induced Vomiting |  |  | | Bingeing |  |  | | Excessive Exercising |  |  | | Other compensatory behaviours |  |  | | | | | | | |
| ***\*Recurrent episodes of binge eating, which is characterised by both eating in a discrete period of time an amount of food that is definitely larger than what most people would eat and a sense of lack of control overeating during the episodes, over a period of at least 3 months. NOTE: This is not the same as overeating. We do not provide a weight management service or assessments for bariatric surgery.*** | | | | | | | | |
| **Relevant History**  *(Detail any past contact with services and self-harm history):* | |  | | | | | | |
| **Co-morbid Needs** | |  | | | | | | |
| **Substance Use History**  *(if applicable)***:** | |  | | | | | | |
| **Other Medical Conditions**  *(if applicable)***:** | |  | | | | | | |
| **Risk Concerns**  *(Please specify if there are any past or current concerns relating self-harm or suicide):* | |  | | | | | | |
| **Physical Health History:** | | | | | | | | |
| Is the patient in Hospital?  Yes   No  Has the patient received IV medication?  Yes   No  How is blood collection being taken?  Venepunture  Yes   No  PICC Line  Yes   No  Central Line  Yes   No  \**PLEASE NOTE: The physical health monitoring of patients being seen in the community ED team remains the responsibility of the GP. We aim to maintain good liaison and consultation with primary and secondary care services involved with your patient’s care throughout treatment.* | | | | | | | | |
| **Current Medication:** | | | | | | | | |
|  | | | | | | | | |
| **Reason for Referral:** | | | | | | | | |
| **Has the patient consented to referral?** | | | | | **Yes No** | | | |
| **Please provide any further relevant information below:** | | | | | | | | |
|  | | | | | | | | |
| **Additional information on referrals process:** | | | | | | | | |
| **\*PLEASE NOTE:**   * Please contact the service on using our email address if you require support with your referral and a member of our team will be able to help you. * Please be aware that if your referral is accepted, the waiting time for the initial assessment depends on acuity and it might be several weeks, although we are working to try and reduce this. * Please be aware that if your referral is accepted and following the initial patient assessment, it is likely that the patient will wait for treatment – unfortunately, we cannot predict how long this is likely to be. * The physical health monitoring of patients being seen in community team remains the responsibility of the GP. | | | | | | | | |