Brighton & Hove Eating Disorder Service Referral Form

Referrer & Team: (if other than GP) **Referrer Fax No.:** **Direct Phone Number:**	**GP & Address:**

Patient Name:	**Address:**
(Mobile) Phone Number :	
D.O.B:	
NHS Number:	**Postcode:**
Height:	**Gender**
Weight: **BMI:**	**Weight stable** **Yes/No;**

Response required	☐ **Routine** (assessment within 4 weeks)	☐ **Priority** (assessment within 5 days- you must complete the form and discuss it with a BHEDS clinician via phone **03003040090**)	**FOR ACUTE MEDICAL NEED REFER FOR MEDICAL ADMISSION IN THE FIRST INSTANCE**

Dear BHEDS,

(Clinical narrative/the history here please **including treatment for eating disorder to date (admissions to eating disorder units, clinician, therapy, other services involved etc.):** attach extra sheet / previous letters if necessary

Type of Eating Disorder:	☐ Anorexia Nervosa	☐ Bulimia Nervosa	☐ Atypical ED
Illness episode	First	Recurrent	**Date of Onset of ED:**
Duration of illness	< 6 months	> 6 months	

Risk issues -if present please attach further details and **if acute refer to ATS /BURS**					
Is the patient having suicidal thoughts?	Yes ☐	No ☐	Is there a risk of self harm	Yes ☐	No ☐
Do they have a plan	Yes ☐	No ☐	Is there a history of self harm?	Yes ☐	No ☐
Is there a history of suicide attempts?	Yes ☐	No ☐	Other risk issues (please add extra sheet)	Yes ☐	No ☐

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Current physical comorbidity

☐ Type I diabetic	☐ Type II diabetic
LMP:	**Pregnant – EDD:**
Past medical Hx/Longterm conditions (auto-populate and review) (Crohn's, IBS, food allergies/intolerances, sensory impairment ect)	
Medication: include EXTRA SHEET	
Allergies	

Current psychological/psychiatric comorbidity (e.g. OCD, PD, depression, anxiety disorders, substance abuse, self-harm, learning disability, perfectionism etc)
Or include in narrative

PHQ-9 score **Date:** **GAD-7 score** **Date:**

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Physical assessment and tests

Markers of high risk, to consider discussion with Medical Consultant

BP (lying & standing):	*high risk if Systolic < 90 or Diastolic < 50*
Postural Drop:	*high risk if > 10*
Pulse:	*high risk if < 50 or irregular*
Temperature:	*high risk if < 35 ^{o}C*
Peripheral Circulation:	*high risk if pale / blue*

Please tick	Low Risk	Moderate Risk	Severe Risk
Laxative abuse/ vomiting	< 3 x a week ☐	> 3 x a week ☐	Daily vomiting or purging ☐
BMI See tests to do below	> 17.5 ☐	15 -17.5 ☐	< 15 and/or rapid weight loss (25% body weight in 6 months) ☐
Physical complicat-ions	none ☐	e.g. amenorrhoea ☐	Meets Moderate criteria & has additional health risks e.g. diabetes or pregnancy. ☐
Required tests depending on above Risks [please organise & attach results where ready]			
FBC,U&E, LFTS, Gluc Ca, K, Mg, CK	Yes	Yes	Yes
TFTS, ESR,CRP	No	No	Yes
ECG*	No	Yes	Yes
DEXA scan **	No	Yes	Yes

***ECG:** *look for lengthening of QTC interval or arrhythmias;*
Seek advice if QTc above 440 for men or above 460 for women and review medication which might prolong QTc:. (http://www.sads.org.uk/drugs_to_avoid.htm)

****DEXA** scan in anorexia nervosa if duration > 6 months

OPTIONAL: Test of Proximal Myopathy (BMI<17.5 or rapid weight loss)	
Squat – *patient is asked to squat and rise without using their hands*	☐ 0 = Completely unable to rise ☐ 1 = Able to rise only with use of hands ☐ 2 = Able to rise only with noticeable difficulty ☐ 3 = Able to rise without difficulty

For office use:

Date referral received		Date & Outcome of Screen		
Date questionnaires sent		Assessment date booked for :		
Outcome		Review	Review	Review