|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CAMHS EATING DISORDERS REFERRAL FORM**  |  |  |  | http://ourspace/SiteCollectionImages/Home/awp-logo-small.jpg |
| Request for Specialist Assessment for people under 18 with suspected or confirmed eating disorders |  |  |  |
|  |  |  |  |  |  |
| Link to all age risk assessment (MEED) guidance and referral pathway <https://remedy.bnssgccg.nhs.uk/children-young-people/eating-disorders/care-pathway/>**Service User Details** |
| Full Name  |   |
| NHS Number  |   |
| DOB  |   | Contact Numbers for parent and/or young person |  |
|  |  |  |  |  |  |
| **Referrer Details** |
| Referrer Name  |   | Contact Number |  |
| Name of GP practice or MH team referring |   |
| Has patient consented to referral? Y / N |  |
|   |   |   |   |   |   |
| **Weight Summary**

|  |  |
| --- | --- |
| Weight (KG’s) |  |
| Height (CM’s) |  |
| Weight for height %BMI [- click to calculate](https://remedy.bnssgccg.nhs.uk/media/5732/combo-weight4height-physobs.xlsx) |  |
| Rapid Weight Loss? Please specify Kg’s over what period of time |  |

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|  |  |  |  |  |  |
| **Main Eating Disorder concerns** |
| Please specify potential ED diagnosis: | AN [ ] BN [ ] BED [ ] Other [ ]  |
| Vomiting? | How frequently? |   |
| Bingeing? | How frequently? |   |
| Food restriction? | How many calories per day? |   |
| Fluid restriction? | How much? |   |
| Laxatives? | How many per day/week? |   |
| Exercise? | How much per day/week? |   |
| Eating Disorder Cognitions  |  |
| **Physical Health/Observations** |
| Pulse (sitting) |   | Pulse (standing)  |   | Menarche: |   |
| BP (sitting) |   | BP (standing) |   | LMP: |
| Temperature |  | Squat test |  |  |  |
| Any other significant medical history? |  |
|
| **Tests** **(MUST BE REQUESTED AT REFERRAL AND COMPLETED WITHIN ONE WEEK OF REFERRAL** **TO ENSURE SAFE TRIAGE BY ED TEAM** |
| Bloods – FBC, U&E, **Phosphate**, Magnesium, LFT, TFT, Calcium, Glucose, Ferritin, Coeliac screen, Vitamin D Clicking the **‘Eating Disorders referral under 18’** profile on ICE system will select these bloods for you | Requested? | Y / N | if no why? |
| Attached to form? | Y / N | If not, when is this booked for?  |
| ECG | Requested? | Y / N | If not, why?  |
| Attached to form? | Y / N | If not, when is this booked for? |
|  |  |
| **Recent consultations** |
| **Past medical history** |
| **Medications** |
|  |  |
| **Mental Health History**(include previous referrals to ED or CAMHS, confirmed of suspected ASD and any other co morbid mental health concerns)Does eating difficulty appear to be primary difficulty? (e.g. not loss of appetite due to low mood or restrictive eating due to anxiety or social circumstances ) |  |
| **Safeguarding concerns**  |  |
| **Any specific risk issues** |  |
| **Current presentation/reason for referral**

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|  |

**Please attach this form to SPE** |