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| **Community Eating Disorders Service STEPS Referral form** | |  | | |  | |  | http://ourspace/SiteCollectionImages/Home/awp-logo-small.jpg |
| Request for Specialist Assessment for people aged 18+ with suspected or confirmed eating disorder. | | |  | | | |  |  |
| ***In BNSSG individuals with binge eating disorder can be referred directly to SWEDA; Please be aware that we are not currently commissioned to work with individuals with avoidant restrictive food intake disorder, however, we will consider each referral and attempt to offer an assessment for all ARFID referrals with a moderate to high risk profile.*** | | | | | | | | |
| **Service User Details** | | | | | | | | |
| Full Name |  | | | | | | | |
| Gender/Pronouns |  | | | | | | | |
| NHS Number |  | | | | | | | |
| DOB |  | | Ethnicity | | |  | | |
| Postal Address (full postal address) |  | | Contact Numbers | | |  | | |
| Sexual Orientation |  | | Religion | | |  | | |
|  |  |  | | |  | |  |  |
| **Referrer Details** | | | | | | | | |
| Referrer Name |  | | Contact Number | | |  | | |
| Name of GP practice or MH team referring | | |  | | | | | |
| Is patient intending to remain in catchment area? Y/ N   **\*** | | |  | | | | | |
| Has patient consented to referral? Y / N | | |  | | | | | |
| \*Please ask about any planned periods away from local area and consider re-referring on return –e.g. if attending university and referral is being made before holiday period. (STEPs assessment to be arranged within 28 days of triage: if unable to attend within this timeframe, referral will be closed and re-referral advised on return.) | | | | | | | |  |
| **Mental Health Status** | | | | | | | | |
| Brief Mental Health History | |  | | | | | | |
| including Drug and Alcohol | |
| Any other teams currently involved? Please specify: | |  | | | | | | |
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|  |  |  | | |  | |  |  |
| **Accessibility/Communication or Disabilities** | | | | | | | | |
| Please specify if this person’s ability to access services or their communication is impacted and may require adjustments, learning difficulties, other disabilities or accessibility issues, autism? | | | |  | | | | |
|  |  |  | | |  | |  |  |
| **Additional Information** | | | | | | | | |
| Perinatal referral? | Yes/No | | Autism or ADHD diagnosis/referred (please specify)? | | | | Yes/No | |
| T1DE (Type 1 Diabetes and Disordered Eating) referral? | Yes/No | | Routine or Urgent Referral? | | | | Routine/Urgent | |
|  |  |  | | |  | |  |  |
| **Weight/BMI** | | | | | | | | |
| Weight (KG’s) (within 28 days) |  | Rapid Weight Loss? Please specify Kg’s over what period of time | | | | |  | |
| Height (CM’s) |  |
| BMI (within 28 days) |  |
|  |  |  | | |  | |  |  |
| **Main Eating Disorder concerns** | | | | | | | | |
| Please specify potential ED diagnosis: | | | AN [ ] BN [ ] OSFED [ ] BED [ ] ARFID [ ] | | | | | |
| 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? | |  | | | | | |
| **Physical Health/Observations** | | | | | | | | |
| Pulse |  | Temperature | | |  | | Pregnant | Y/N |
| BP |  | Menstruation | | |  | |
| Muscle strength / SUSS test (able to perform?) | |  | | | | | | |
| Any other significant history? | |  | | | | | | |
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|  |  |  | | |  | |  |  |
| **Tests** | | | | | | | | |
| **Bloods** – Within 28 days of referral – FBC, U&Es, LFTs, CK, Glucose (NON-fasting), Magnesium, Phosphate (Plus TFTs and haematinics if no recent TFTs and haematinics.) | | Abnormal? | | | Y / N | | | |
| Attached to form? | | | Y / N | | | |
| **For T1DE referrals only** – most recent HbA1c result: (if most recent HbA1c >75 referral will be triaged as urgent.) | | Result: | | |  | | | |
| Date of test: | | |  | | | |
| **ECG** – If clinically indicated (indications may include low BMI, rapid weight loss, frequent purging including vomiting/laxatives/diuretics, bradycardia, hypotension, electrolyte abnormality, any previous abnormal heart rhythm, etc. | | Abnormal? | | | Y / N | | | |
| Attached to form? | | | Y / N | | | |
|  |  |  | | |  | |  |  |
| **Current Presentation/Reason for Referral** | | | | | | | | |
|  | | | | | | | | |

**Please email completed form to** [**awp.STEPs@nhs.net**](mailto:awp.STEPs@nhs.net) Acer Unit, Blackberry Hill Hospital, Bristol BS16 2EWTelephone: 0117 3546920