**Referral Form**

|  |  |  |  |
| --- | --- | --- | --- |
| Referral Date: |  | | |
| Surname: |  | | |
| Forename: |  | | |
| D.O.B: |  | | |
| Gender: |  | | |
| NHS Number: |  | | |
| Address & Postcode: |  | Home Telephone No: |  |
| Mobile Telephone No: |  |
| Preferred time  for a return call: |  |

|  |  |
| --- | --- |
| Referrer Name  and Contact Details: |  |
| Referring Service: |  |

|  |
| --- |
| Cluster (if known) |
| (1-4)  (5+) |

|  |  |  |  |
| --- | --- | --- | --- |
| GP: |  | | |
| GP Address: |  | | |
| GP Tel. No.: |  | Date last seen by GP: |  |

|  |  |
| --- | --- |
|  | Please indicate: **Yes, No** or **Don’t know** |
| Does the patient have any communication needs? | Yes  No  Don’t Know |
| **If yes please state:** | |
| Is the patient aware of the referral? | Yes  No  Don’t Know |
| Has the patient consented to share their information? | Yes  No  Don’t Know |

|  |
| --- |
| Eating disorder behaviours and thoughts: |
|  |
| Physical health information i.e. Pregnancy, Diabetes and weight if known: |
|  |
| Mental health signs and symptoms: |
|  |
| Any other services involved: |
|  |

**Risk Summary details: (Historic and Current)**

|  |
| --- |
| Suicide: |
|  |
| Other Self Harm: |
|  |
| Substance Misuse: |
|  |
| Other Risks: |
|  |
| Safeguarding – Children/Adults: |
|  |
| Aggression/Violence: |
|  |

**Binge Eating Disorder Screener-7 (BEDS-7)**

|  |  |
| --- | --- |
|  | Please indicate: **Yes** or **No** |
| **1. During the last 3 months**, did you have any episodes of excessive overeating (i.e. eating significantly more than what most people would eat in a similar period of time)? | Yes  No |
| **NOTE: IF YOU ANSWERED “NO” TO QUESTION 1, YOU MAY STOP.**  **THE REMAINING QUESTIONS DO NOT APPLY TO YOU.** | |
| **2.** Do you feel distressed about your episodes of excessive overeating? | Yes  No |

|  |  |
| --- | --- |
|  | Please indicate: **Never or Rarely**, **Sometimes**, **Often** or **Always** |
| **3. During your episodes of excessive overeating**, how often did you feel like you had no control over your eating (e.g. not being able to stop eating, feel compelled to eat, or going back and forth for more food)? | Never or Rarely  Sometimes  Often  Always |
| **4. During your episodes of excessive overeating**, how often did you continue eating even though you were not hungry? | Never or Rarely  Sometimes  Often  Always |
| **5. During your episodes of excessive overeating**, how often were you embarrassed by how much you ate? | Never or Rarely  Sometimes  Often  Always |
| **6. During your episodes of excessive overeating**, how often did you feel disgusted with yourself or guilty afterward? | Never or Rarely  Sometimes  Often  Always |
| **7. During the last 3 months**, how often did you make yourself vomit as a means to control your weight or shape? | Never or Rarely  Sometimes  Often  Always |

**SCOFF Questions (Not appropriate for Binge Eating Disorder)**

|  |  |
| --- | --- |
|  | Please indicate: **Yes** or **No** |
| **1.** Do you make yourself **s**ick because you feel uncomfortably full? | Yes  No |
| **2.** Do you worry you have lost **c**ontrol over how much you eat? | Yes  No |
| **3.** Have you recently lost more than **o**ne stone in a 3 month period? | Yes  No |
| **4.** Do you believe yourself to be **f**at when others say you are thin? | Yes  No |
| **5.** Would you say **f**ood dominates your life? | Yes  No |

|  |
| --- |
| Supporting Information: |
|  |