**Referral Form**

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

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

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

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

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|  | 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 |

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| 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)**

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

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

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|  | 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 |

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|  | 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)**

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| --- | --- |
|  | 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 |

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| Supporting Information: |
|            |