**Referral to the Eating Difficulties and ARFID Service**

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| **Date of Referral** |  |  |

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| **Section 1: Patient Details** |
| **Has the family/young person agreed to this referral?** | [ ]  **Yes** | [ ]  **No** |
| **Who has given consent for this referral?**  |  |
| **Full Legal Name** |  | **D.O.B** |  |
| **Preferred name** *(if different)* |  | **Sex assigned at Birth**  | [ ]  **Female** | [ ]  **Male** |
| **Address**  | **POSTCODE:** | **Patient Phone / Mobile** |  |
| **Carer Phone / Mobile** |  |
| **NHS Number** |  | **Patient email** |  |
| **Int*e*rpreter Required?** | [ ]  **Yes** | [ ]  **No** | **If required, what language** |  |
| **Does the patient have any other communication support needs**? | [ ]  **Yes** | [ ]  **No** | **If yes, please give more information** |  |
| **Who does CYP live with?** |  | **Is the referred CYP an ex-member of British armed forces or dependent on such a person?** | [ ]  **No**[ ]  **Don’t Know** [ ]  **Yes, ex-services member**[ ]  **Yes, dependant of an ex-services member** |
| **Ethnicity Code** |  |
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| **Ethnicity codes** |
| (A) White British(B) White Irish(C) Other White background(D) White and Black Caribbean | (E) White and Black African(F) White and Asian(G) Other mixed background(H) Indian | (J) Pakistani(K) Bangladeshi(L) Other Asian background(M) Caribbean | (N) African(P) Other Black background(R) Chinese(S) Any other ethnicity group |

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| ***Patients 18 and over*** | **Employment status** |  | **Current accommodation***Living alone/ with friends or family etc.* |  |
| **Marital status** |  |
| **Family Members** *relevant to referral* | **Relationship** | **Living at above address Y/N**  | **DOB** | **M/F** |
| **First Name** | **Surname**  |
| Aide |  | Mother | Y |  | F |
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| **Who has Parental Responsibility?**  | **Mother** |

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| **Please tick those that apply:** |
| **Child in Need** | [ ]  **Yes** | [ ]  **No** | [ ]  **Historic** |
| **Child Protection Plan** | [ ]  **Yes** | [ ]  **No** | [ ]  **Historic** |
| **Looked After Child** | [ ]  **Yes** | [ ]  **No** | [ ]  **Historic** |
| **Special Guardianship Order** | [ ]  **Yes** | [ ]  **No** | [ ]   **Historic** |
| **Residence Order** | [ ]  **Yes** | [ ]  **No** | [ ]  **Historic** |
| **Adopted** | [ ]  **Yes** | [ ]  **No** | [ ]  **Historic** |
| **Youth Offending Order**  | [ ]  **Yes** | [ ]  **No** | [ ]   **Historic** |
| **Previous CAMHS Involvement** | [ ]  **Yes** | [ ]  **No** | [ ]  **Historic** |

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| **Section 2: Primary Reason for referral (mandatory NHSEi Information) Please select only one main reason.** |
| [ ]  First Episode Psychosis  | [ ]  Adjustment to health issues | [ ]  Anxiety |
| [ ]  Attachment Difficulties | [ ]  Bi polar disorder | [ ]  Conduct disorder |
| [ ]  Depression/ low mood | [ ]  Drug and Alcohol  | [ ]  Eating disorders |
| [ ]  Family relationship difficulties | [ ]  Gender discomfort  | [ ]  In crisis  |
| [ ]  Neurodevelopmental conditions  | [ ]  Obsessive compulsive disorder  | [ ]  Ongoing or Recurrent Psychosis  |
| [ ]  Organic Brain disorder | [ ]  Perinatal mental health issues | [ ]  Personality disorders  |
| [ ]  Phobias | [ ]  Post-traumatic stress disorder | [ ]  Self-care issues |
| [ ]  Self-Harm behaviours | [ ]  Unexplained physical symptoms  |

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| **Section 3: Pre-referral discussion –**  |
| **Has there been a Pre-referral Discussion**  | [ ]  **Yes** | [ ]  **No** |  |
| **If yes, who was the discussion with?** |  |
| **Date of discussion**  |  |
| **If “Yes”, and a referral has been agreed to, what was the agreed plan, and which CAMHS team, and which CAMHS practitioner will be allocated?** |
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| **Section 4: Referral Information** |
| **What are you thinking the Eating Difficulties and ARFID Service can do that would be helpful?**  |
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| **Please describe the current eating difficulties, how severe they are, what impact they have on functioning (school, home life, etc.), how long they have been present, and any issues about risk to self or others.** |
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| **What has been done already to try and help, what other services have the family worked with and what was the outcome?**  |
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| **Section 5: Medical Information** |
| **Weight (kg)** |  |
| **Height (cm)** |  |
| **BMI or weight for height** |  |
| **Weight history (previous dated weights during the last year if available):** |  |
| **Rate of Weight Loss: Estimated or Actual?**  | Comment: |
| **Estimated Daily Food and Fluid Intake / Eating Patternincluding estimated daily calorie intake, types of food, fluid, food avoidance or food fears if possible:** |  |
| **Compensatory Behaviours:** **(Please give details of frequency and amounts)** | □ Purging □ Laxatives □ Excessive exercise □ Binge eating |
| **Physical Concerns** **E.g. blood pressure, heart rate, temperature:**  |  |
| **Physical Health Conditions:****(If applicable)** |  |
| **Any medications:**  |  |
| **Other Investigations Completed (Including bloods / ECG)?** **Please attach results:**  |  |
|  **Risk Assessment****Please describe the physical and psychological risk present?** **(i.e. safeguarding concerns, self-harm, suicidality, and whether the young person is medically stable)** |  |
| **Menstruation History****e.g. onset, regularity, any changes, have periods stopped?** |  |
| **Any Other Medical** **History?** |  |

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| **Section 6: Mental Health Information** |
| **Mental Health History (including contact with CAMHS):**  |   |
| **Current Mental Health Concerns (Co-morbidity):** |  |
| **Eating Difficulties Cognition** **e.g. weight and shape concerns, avoidance of certain foods, smells and textures** |  |

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| **Section 7: Professional Network** |
| **GP Details** |
|  **GP Name** |  | **GP Practice Name** |  |
| **GP Address** |   | **GP Telephone** |  |
| **Permission to Contact?** | [ ]  **Yes** | [ ]  **No** | [ ]  **Don’t Know** |
| **School Details** |
|  **School** |  | **Name of School Contact**  |  |
| **School Address** |  | **School Telephone** |  |
| **Permission to Contact?** | [ ]  **Yes** | [ ]  **No** | [ ]  **Don’t Know** |
| **Referrer Details** (*only if the referrer is* ***not*** *the patient’s GP)* |
| **Referrer Name** |  | **Referrer Job Title** |  . |
| **Referrer Address** |  | **Referrer Email** |  |
| **Referrer Telephone** |  |
| **Permission to contact?** | [ ]  **Yes** | [ ]  **No** | [ ]  **Don’t Know** |

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| **Section 8 - Other Services/ Professionals Involved:** |
| **Name** |  | **Address** |  |
| **Service** |  |
| **Contact no** |  | **Permission to contact?** | [ ]  **Yes** | [ ]  N**o** | [ ]  D**on’t Know** |

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| **Name** |  | **Address** |  |
| **Service** |  |
| **Contact no** |  | **Permission to contact?** | [ ]  **Yes** | [ ]  **No** | [ ]  **Don’t Know** |

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| ***Office use only***  |
| **Clinician** |  | **Appointment date** | **DD / MM / YYYY** |
| **Codes: Referral problem** |  | **Referral reason** |  |
| **Client No.** |  | **CAMHS’s action** |  |

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| **Once completed send to:** |
| **Email** | tpn-tr.CYAF-Intake@nhs.net |
| **Post** | CYAF CAMHS referrals120 Belsize LaneLondon, NW3 5BA |