To make a referral email or send this form to:

**Kent and Medway Eating disorder Service**

Address: The Courtyard - Pudding Lane, Maidstone, Kent ME14 1PA

Telephone: 0300 3001980

Email: [nem-tr.eds.kentandmedway**.**referrals@nhs.net](mailto:nem-tr.eds.kentandmedway.referrals@nhs.net)

Email: xxxxxxxx

**Kent and Medway Eating Disorder Service**

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| **Section 1** | **Client Details** | | | | | | | | | | | |
| Client’s Name:  (Surname) (First Name) | | | | | | M  F | | | | | Date of Birth | |
| Address: | | | | | | | | | | | Client ’s Preferred Method of Contact:  Letter:  Letter:  Text:  Email: | |
| Postcode: | | | | Email Address: | | | | | | | First Language: | |
| Home Telephone: | | | | Client ’s Mobile: | | | | | | | Interpreter required:  Yes  No  Specify Which Language: | |
| NHS Number: | | | | Social Services ISIS Number  (if applicable): | | | | | | | Does the client have a disability:  Yes  No  Please specify: | |
| Religion: | | | | Nationality: | | | | | | | Ethnicity: | |
| GP Name: | | | | | | | | | | | GP Telephone Number: | |
| GP Surgery Address:    Email | | | | | | | (If applicable) Subject to Child Protection Plan / Child In Need:  Y  N  LAC Status: | | | | | |
| Attends school/college  Employed  Unemployed | | | | | | | Marital Status:  Dependent Children: Yes  No | | | | | |
| Name of School / College (if applicable):  Address:    Telephone:  Contact Name: | | | | | | | Smoking Status : Non Smoker  Smoker  Substance Use Status: Alcohol  Recreational substances  Controlled drugs | | | | | |
| **Section 2** | To Be Completed for < 18 Year Clients  **Next of Kin and Parental Responsibility Details:** | | | | | | | | | | | |
| Name of Person(s) with Parental Responsibility? | | | | | | | | | | Interpreter required:  Yes  No  Specify Which Language: | | |
| Parent / Carer’s Name (if different from above): | | | | | | | | | | Relationship to Young Person: | | |
| Address:  Postcode: | | | | | | | | | | Telephone: | | |
| Mobile: | | |
| Email Address: | | | | | | | | | | | | |
| **Section 3** | **Reason for Referral and Details about Client ’s Difficulties:** state nature of difficulties,  onset, frequency, duration, interventions tried, any relevant medical history | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **(Please note weight, height and BMI are mandatory fields and the referral cannot be processed without this information)** | | | | | | | | | | | | |
| Height: | | | Weight:  Weight change in last  three months: | | | | | BMI Centile if <18years: | | | | BMI if >18years: |
| **Do not delay referral waiting for test results.** | | | | | | | | | | | | |
| Date of Last Blood Test  FBC  LFT  Calcium  Phosphate | | | **Test Results**:  Magnesium  Random Glucose  Coeliac Screen  TSH | | | | | ESR  CRP  Presence of DSH | | | | Date of Last EGG  Result: |
| **Section 4** | **Impact on Client :**  E.g. Please describe how this impacts on the client ’s behaviour, social development, school/nursery/college performance/attainment, relationships, activities, emotional/psychiatric wellbeing, and physical health/routines. | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| |  |  | | --- | --- | | **Section 5** | **Risk Factors:** | | | | | | | | | | | | | |
| Suicidal Ideations Yes  No  please specify:    Self-Harm Yes  No  please specify:    Concerns for safety of others Yes  No  please specify:    Do you consider it safe to see this client on a one to one basis Yes  No  please specify: | | | | | | | | | | | | |
| |  |  | | --- | --- | | **Section 6** | **Outcomes:** | | | | | | | | | | | | | |
| **Client :**  Please give details of what the client would like to happen as a result of this referral.  Concerns for safety of others Yes  No  please specify: | | | | | | | | | | | | |
| **Referrer:**  In making this referral, what outcomes are you anticipating for the client and expectations of what the EDS team can offer?  Concerns for safety of others Yes  No  please specify: | | | | | | | | | | | | |
| |  |  | | --- | --- | | **Section 7** | **Other Agencies Involved:** | | | | | | | | | | | | | |
| Service Name Location Telephone number  1.  2.  3.  4. | | | | | | | | | | | | |
| **Section 8** | **Name and Contact Details of Person Making Referral:** | | | | | | | | | | | |
| Name: | |  | | | Address: | | | |  | | | |
| Job Title or Relationship  to client: | |  | | |
| Agency (if professional  making the referral): | |  | | |
| Telephone: | |  | | | Email: | | | |  | | | |
| Date last saw the client | | | | | | | | | | | | |
| **Section 9** | **Information Sharing And Consent:**  **Please note this section is important and MUST be completed** | | | | | | | | | | | |
| Information about the client may be shared with other teams and agencies (e.g. Education services, Children’s Centres and social care) in order to identify the most appropriate support for your you/your child.  If client is >18years; has the referral been discussed with the client or carer  **Yes  No**  If client is >18years does the client or carer consent to this referral?  **Yes  No**  If client is >18years has consent been received for enquiry/onward referral to other agencies?  **Yes  No**  If client is <18years; has the referral been discussed with the child or young person?  **Yes  No**  If client is <16years; does the child or young person consent to this referral?  **Yes  No**  If client is <16years Is there parental consent for enquiry/onward referral to other agencies?  **Yes  No**  **Comments (if any):**    **Client signature       Name:       Date:**  **If client < 16 years; Relationship to child/young person:**  **Signed (referrer):** **Name:** **Date:** | | | | | | | | | | | | |