**Under 18’s Community Eating Disorder Service (CEDS) for North Cumbria**

**Referral Form**

** Please complete all sections as fully as possible. Recent (within last 2 weeks) physical health observations must be included for referrals to be considered**

Completed forms to be emailed to [CEDSAdmin@CNTW.nhs.uk](mailto:CEDSAdmin@CNTW.nhs.uk) Postal referrals will not be accepted.

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| **Child/Young person’s details** | | | |
| **First Name** |  | **Family Name** |  |
| **NHS No.** |  | **Date of Birth** |  |
| **Age** |  | **Ethnicity** |  |
| **Religion** |  | **Gender** |  |
| **Preferred Pronouns** |  | **Preferred name** | with a great quote from the document or use this space to emphasize a key point. To place this text box anywhere on the page, just drag it.] |
| **Address** |  | **Contact Details**  Home Phone:  Mobile Phone:  Work Phone  Email: |  |
| **Preferred Language** |  | **Interpreter Required?** | Yes  No  If yes, please provide details of language including signing |
| **Does the child/young person or family members / carer have any physical or communication needs?**  Especially in regards arranging/attending appointments? | | Yes  No  If yes, please provide details of needs and adjustment requested | |
| **Are there any other considerations, such as culture, language, illness, religion or disability, when making contact with the Child / young person or family members / carers?** | | Yes  No  if yes please provide details | |

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| **Family / Carer Details** | | | |
| **Name of parents/carers** |  | **Relationship to child / young person** |  |
| **Address**  **(**if different from young person) |  | **Contact Details**  (if different from young person) |  |
| **Who holds parental responsibility** Please give contact details if not already shown above. | |  | |
| **Is the child / young person “looked after” as defined in the Children’s Act 1989?** | | Yes  No | |
| **Are there any Safeguarding concerns?** | | Yes  No  If Yes, please give details | |
| **Is the child / young person adopted?** | | Yes  No | |
| **Is the child / young person subject to Child Protection Plan?** | | Yes  No | |

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| **GP Details** | | | |
| **Name** |  | **Address** |  |
| **Telephone** |  | **Email** |  |

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| **Consent** | |
| **Has the referral been discussed with parents/carers (who have parental responsibility)?** | Yes  No  If No, please give details |
| **Do the parents/carers (who have parental responsibility) consent to this referral?** | Yes  No  If No, please give details |
| **We may need to contact any of the organisations mentioned in the referral, including GP and school. Has the parents/carers (who have parental responsibility) consented to contact these organisations?** | Yes  No  If No, please give details |
| **Has the referral been discussed with Child / young person?** | Yes  No  If No, please give details |
| **Does the child / young person consent to this referral?** | Yes  No  If No, please give details |
| **We may need to contact any of the organisations mentioned in the referral, including GP and school. Has the child / young person consented to contact these organisations?** | Yes  No  If No, please give details |

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| **Physical Health – Please respond to risks as appropriate including consideration of paediatric admission if clinically indicated.** | | | |
| **Physical health check** Remove shoes, coat, jumper and items from within pockets. | | | |
| **Recent physical health check** |  | **Carried out by?** |  |
| **Weight** (kg) |  | **Height** (cm) |  |
| **BP Sitting** |  | **BP Standing** |  |
| **Temperature Tympanic** |  | | |
| **Pulse Sitting** |  | **Pulse Standing** |  |
| **Allergies,** please provide details | | |  |
| **Medical Conditions,** please provide details | | |  |
| **Blood Investigation & results** FBC, U&Es, LFTs, Phosphate, Thyroid Function Tests, bone profile, cardiac profile, B12/folate). | | |  |
| **Other Physical Health causes which may influence the condition,** please provide details | | |  |
| **Other Investigations & Results,** please provide details | | |  |

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| **Historical Changes in Height and Weight** | | |
| **Date** | **Height** | **Weight** |
|  | cm | kg |
|  | cm | Kg |
|  | cm | Kg |

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| **Current Presentation** | | |
| **Mental Health Concerns** | | |
| **Mental health concerns,** including self-harm / suicidal ideation/behaviour  Please consider contacting the crisis service if there are significant concerns in this area  **Telephone: 08006522865** | | Yes  No  If yes, please provide details |
| **Eating disorder behaviour and symptoms** | | |
| **Trying to change weight or shape?** | Yes  No  If yes, please provide details | |

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| **Current Presentation – Please contact us if concerned about risk** | |
| **Behaviour,** pleaseselect all that are relevant | |
| **Vomiting** | Yes  No  If yes, please provide details |
| **Restricting intake** | Yes  No  If yes, please provide details |
| **Limiting variety of food** | Yes  No  If yes, please provide details |
| **Using Laxatives** | Yes  No  If yes, please provide details |
| **Other purging methods, diet pills etc** | Yes  No  If yes, please provide details |
| **Bingeing** | Yes  No  If yes, please provide further details |
| **Excessive exercise** | Yes  No  If yes, please provide further details |
| **Body image issues** | Yes  No  If yes, please provide further details |
| **Any other Information,** please provide details |  |
| **Periods** | |
| **Have child/young person’s periods started?** | Yes  No  If yes, what age did they start? |
| **How regular are they?** | Mostly regular  On and Off  Stopped  NA  If stopped or on and off, when was the last period? |
| **Is child/young person using any medication which may affect menstrual cycle?** | Yes  No  If yes, what type |

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| **Further Information** | |
| **Please provide any further information affecting the child / young person not mentioned above** |  |

Date: January 2023

Review: January 2024