Best care by the best people

NELFT NHS
NHS Foundation Trust

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

Kent and Medway Eating Disorder Service

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	**Test Results**:		Date of Last EGG
FBC LFT Calcium Phosphate	Magnesium Random Glucose Coeliac Screen TSH	ESR CRP Presence of DSH	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:**