**Referral Form   
Adult Eating Disorder Service – St Vincent’s University Hospital**

***Wicklow, Dun Laoghaire, Dublin South East (CHO 6)***

**Referrer details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Referred by** |  | **Date of Referral** |  |
| **Phone Number** |  | **Email Address** |  |
| **Practice Address** |  | | |

**Patient details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient name** |  | | |
| **Address**  (CHO 6 only) |  | | |
| **Date of birth** |  |  **under 18, please phone to discuss** | |
| **Phone number** |  | **Email Address** |  |
| **Please be advised that if adequate information is not provided it will not be possible to process the referral** | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Reason for referral**  (i.e. diagnosis, current issues) |  | | | | |
|  **Patient aware of referral** | |  **Patient willing to attend service** | | |  |
| **Previous/current eating disorder treatment**  (please include reports, etc if available) |  | | | | |
| **Weight (kg)** | | | **Height (cm)** | **BMI**  (weight in kg/height in m²) | |
| **Recent weight changes**  *(include time period)* | | |  | | |
| **Blood Pressure**  (+ postural change) | | | **Heart Rate**  (+ postural change) | **Temperature** | |

 **Please include a copy of recent blood results** *including FBC, WBC, U&Es, LFTs, bone profile, glucose, phosphate, and magnesium*

 **ECG indicated (blood test abnormality, cardiac signs/symptoms, BMI is less than 15kg/m²) please attach a recent ECG**

**Eating disorder behaviours**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Additional info (frequency, duration, severity, recent change, etc)** |
| **Restricting intake** |  |  |  |
| **Vomiting** |  |  |  |
| **Bingeing** |  |  |  |
| **Laxatives** |  |  |  |
| **Over exercise** |  |  |  |
| **Diet pills** |  |  |  |
| **Alcohol misuse** |  |  |  |
| **Drug misuse** |  |  |  |

**Other information**

|  |  |
| --- | --- |
| **Medical history**  (incl. medical presentation secondary to eating disorder) |  |
| **Psychiatric history** |  |
| **Medication** |  |
| **Risk to self or others**  (e.g. self-harm, suicide, abuse, violence) |  |
| **Other relevant information** |  |

**Please send referrals to -** Email: eatingdisorders@svhg.ie

or

Clinical Coordinator,

Adult Eating Disorder Service,

Elm Mount Lower,

St Vincent’s Hospital,

Elm Park,

Dublin 4,

Tel: 01 2214627