Ashley Cross
Eating Disorders Service

Ashley Cross Eating Disorders Service: Referral Form

Address: BWT, 1 Springfield Road, Poole, England, BH14 0LG
Telephone: 07513759741 Email: hello@ACEDS.co.uk

ACEDS offers assessment and treatment for people with eating disorders. The referral form must be **completed in full** for us to determine if referral criteria have been met. If you have any queries about whether a referral is appropriate, please contact the service. Please email the completed referral form so that our team can get in touch with the client.

Name and address of referring GP/Team: **(include name of referrer and email address)**	

GP name and address			
Client name:		NHS No:	
Address:			
Telephone:		Date of birth:	

Reason for referral:	

Physical Health

Weight:	Height:	BMI: (weight in kg / height in m^2)
BP:	Pulse:	

Please confirm recent blood results (from within the last month)
Blood tests to include: FBC, WBC, LFTs, U & Es, phosphate, magnesium, ESR, Fe studies (**additional if no menstruation in last 6 months** bone profile, cardiac profile, B12/folate)

If **BMI <16.5,** please confirm that a recent ECG has been completed

Eating Disordered Behaviours

Vomiting	Yes	No	**If "YES" how frequent** Must be completed or referral will not be accepted
Using laxatives	Yes	No	**If "YES" how frequent** Must be completed or referral will not be accepted
Bingeing (eating a large amount of food in a short time with a feeling of loss of control)	Yes	No	**If "YES" how frequent** Must be completed or referral will not be accepted
Is weight now stable / falling / increasing (please circle)			

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History of Eating Difficulties

Please give details about history including previous treatment

Other information

Please highlight any risks (to self or others):
Any other services involved?
Is the person aware of this referral and are they motivated to seek help?

What is the client's preferred language?

Is this patient a Type 1 Diabetic (Insulin Dependent)	Yes	No
If yes: Who manages their diabetes? GP or Specialist Service		

Service request list (please tick appropriate)

One-to-one Psychological Therapy	
One-to-one Dietetic/Nutrition Support	
One-to-one occupational therapy	
Binge Eating Group Program	
Anorexia/Bulimia Support Group	
Day Program Workshops (mindfulness, meal planning and relapse prevention)	

REFERRERS' CHECKLIST

Is form complete (including frequency of behaviours)?	
Are blood tests attached?	
If BMI < 16.5 is ECG attached?	
Any additional info attached?	

For office use only Outcome of validation meeting: