CONNECT: The West Yorkshire Adult Eating Disorders Service

Newsam Centre, Seacroft Hospital, Leeds LS14 6WB

[connectreferrals.lypft@nhs.net](mailto:connectreferrals.lypft@nhs.net)

[connectenquiries.lypft@nhs.net](mailto:connectenquiries.lypft@nhs.net)

T. 0113 855 6400

F. 0113 855 6401

**CONNECT Referral Form**

Please see our guidelines for referrers which can be located here: [*https://www.leedsandyorkpft.nhs.uk/our-services/connect-west-yorkshire-adult-eating-disorders-service/more-about-us-and-how-to-refer/*](https://www.leedsandyorkpft.nhs.uk/our-services/connect-west-yorkshire-adult-eating-disorders-service/more-about-us-and-how-to-refer/)

**CONNECT cannot accept referrals unless ALL the relevant information is provided below. Once completed please email to:** [**connectreferrals.lypft@nhs.net**](mailto:connectreferrals.lypft@nhs.net)**.**

**Please also send copies of**

* most recent ECG
* most recent blood results

**NOTE: We need to be in receipt of bloods and ECG from the past 4 weeks. Referrals will not be processed without these up to date investigations attached, and will be returned to referrer.**

**DATE OF REFERRAL:**

**PATIENT DETAILS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name |  | | | | |
| Gender |  | | | | |
| DOB |  | | | | |
| Sexual Orientation |  | | | | |
| Home address |  | | | | |
| Patient email |  | | | | |
| NHS number |  | | | | |
| Contact telephone number |  | | | | |
| Next of kin contact details |  | | | | |
| Ethnicity |  | | | | |
| If student, please state University and course |  | | | | |
| Interpreter required | Yes | No | | Don’t know | |
| Duration of eating disorder < 3 years | Yes | | No | | Don’t know |
| Patients’ opinion of referral to inpatient/community treatment (please delete as appropriate) | Aware and consents to referral  Aware but does not consent to referral  Not aware of referral  Other (please specify) | | | | |

**REFERRER DETAILS**

|  |  |
| --- | --- |
| Name |  |
| Profession |  |
| Work address |  |
| Contact telephone number |  |
| Email address |  |
| **If Referral is from another eating disorder service, please attach all relevant documents.** | |

**GP DETAILS**

|  |  |
| --- | --- |
| Name, address, and email |  |

|  |  |
| --- | --- |
| Involvement with other services/health professionals? If so, please provide contact details |  |

**CLINICAL INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Reason for referral: (**Please detail relevant information including presence of eating disorder thoughts, dietary restriction, compensatory behaviours, and detail of weight change in recent months/weeks.) | | | | |
| **Is this referral form for** | Inpatient | Community | | Don’t know |
| **Dietary restriction** | | YES | NO | If YES how frequent? (**MUST be complete or referral will not be accepted)** |
| **Bingeing** | | YES | NO | If YES how frequent? (**MUST be complete or referral will not be accepted)** |
| **Vomiting** | | YES | NO | If YES how frequent? (**MUST be complete or referral will not be accepted)** |
| **Laxative misuse** | | YES | NO | If YES how frequent? (**MUST be complete or referral will not be accepted)** |
| **Over-exercising** | | YES | NO | If YES how frequent? (**MUST be complete or referral will not be accepted)** |
| **Pregnant** | | YES | | NO |
| **Type 1 Diabetes (T1DE)** | | YES | | NO |

|  |  |
| --- | --- |
| **Weight (kg)** |  |
| **Height (m)** |  |
| **BMI (wt/ht2)** |  |
| **Rate of weight loss (if applicable)** |  |

|  |  |
| --- | --- |
| **B/P:** | **Pulse:** |

**RISK SUMMARY:**

|  |  |  |
| --- | --- | --- |
|  | Current | Previous |
| **Psychological issues** (Please comment on Mood/psychiatric comorbidities/ risk |  |  |
| **Suicidal intent/ DSH /overdoses**  (If applicable) |  |  |
| **Forensic History**  (If applicable) |  |  |
| **Substance misuse**  (If applicable) |  |  |
| **Absconding** |  |  |
| **Safeguarding issues** |  |  |
| **Child protection issues** |  |  |

**Medication**

|  |
| --- |
|  |

**Other mental health diagnosis**

|  |
| --- |
|  |

**Neurodevelopmental diagnosis (Do they have a CTR-Care & Treatment review?)**

|  |
| --- |
|  |

**Allergies (please list and give details)**

|  |
| --- |
|  |

**Food intolerances (please list and give details if medically confirmed)**

|  |
| --- |
|  |

**Dietary requirements (e.g. vegan, halal etc)**

|  |
| --- |
|  |

**Any other information:**

|  |
| --- |
|  |