**CONNECT: The West Adult Eating Disorders Service**

Medical Emergencies in Eating Disorders (MEED) referral form

This referral form should be completed by the referrer and copies sent to:

* The local receiving medical or gastroenterology team
* The local bed manager on-call
* The CONNECT Eating Disorders team ([connectenquiries.lypft@nhs.net](mailto:connectenquiries.lypft@nhs.net))
* The local Liaison Psychiatry team
* The local MEED expert working group

If you are not sure of who these contacts are please contact the CONNECT team on 0113 855 6400 or email [connectenquiries.lypft@nhs.net](mailto:connectenquiries.lypft@nhs.net).

A copy of this form should be filed in the patient’s notes immediately on arrival to the medical ward.

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| --- | --- |
| Patient name |  |
| DOB |  |
| Age |  |
| NHS number |  |
| Address |  |
| Patient contact telephone number |  |
| Responsible Clinician from eating disorders service and contact number |  |
| Lead professional from eating disorders service and contact number |  |
| Current BMI |  |
| Other physical health concerns (e.g. biochemical abnormalities, clinical symptoms/signs, ECG changes) |  |
| NG feeding required |  |
| Eyesight RMN nursing observations required during medical admission |  |
| Does the patient consent to medical admission? |  |
| Does the patient consent to the proposed medical treatment? |  |
| Mental Health Act status |  |
| Frequency of support from eating disorders team during medical admission (minimum weekly) |  |
| Frequency of support from liaison psychiatry team during medical admission (minimum weekly) |  |
| Current medication |  |
| Discharge plan including target BMI if applicable |  |
| Other information |  |
| Referrer details including contact telephone number and email |  |
| Date |  |