

Information for parents/carers/GPs or clinicians considering a private referral to Ellern Mede Outpatient Service for a suspected eating disorder in a patient under the age of 18 or between the ages of 18 and 22. This form should be emailed to Outpatients@ellernmede.org

Patient Information			
Name:		NHS No:	
Date of Birth:		Gender:	
Address:		Tel Home:	
School/College/ information		Tel Mobile:	
Referrer Information			
Referrer:		Job Title:	
Referrer Address:			
Signature:		Date:	
Usual GP:			
GP Surgery:			

Current Difficulties / Risks:			
Relevant Medical history:			
Current medication			
Allergies:			
Other agencies involved in care:			
SCOFF Questionnaire		One point for every "yes"; a score of ≥ 2 indicates a likely case of anorexia nervosa or bulimia	
Do you make yourself Sick because you feel uncomfortably full?		/1	
Do you worry you have lost Control over how much you eat?		/1	
Have you recently lost more than One stone in a 3 month period?		/1	
Do you believe yourself to be Fat when others say you are too thin?		/1	
Would you say that Food dominates your life?		/1	Total /5

Physical health									
Weight		Height		BMI		BMI %			
Blood pressure Lying Standing				Squat Test:					
Heart rate: Lying Standing *Please perform ECG if HR<50				Temperature:					
Investigations:									
FBC		U & Es		LFTs		Glucose		TFTs	
Phosphate		Magnesium		Calcium		Ferritin		Vit D	

Any other relevant information including Co-morbid psychiatric difficulties for e.g. Major depressive disorder, OCD, Anxiety, ASD , Tic Disorder, Epilepsy .