

## ABBI Clinic Referral Form

**Date:**

**Referrer name:**

**Job role:**

**Email address:**

**Telephone:**

Please fill in as much information as possible to allow appropriate triage and to avoid delays in processing.

### Patient Details

Title:

Name:

Address:

Gender:

DOB:

Age:

NHS number:

Tel:

Email:

### GP Details

GP:

GP Practice:

Address:

Email:

Tel:

ICB locality:

# Clinical Information

## Suspected eating disorder diagnosis (please tick):

Anorexia Nervosa

Bulimia Nervosa

ARFID

Binge Eating Disorder

Other

## Clinical details:

Current weight:

Current height:

Current BMI:

## Please tick the relevant boxes below and add comments regarding frequency:

Food restriction

Vomiting

Bingeing

Compulsive exercise

Laxative abuse

Diuretic abuse

Use of slimming aids

# Clinical Presentation

**Psychiatric history:**

**Relevant medical history (including current medication):**

**Please attach recent physical health investigations:**

Bloods:

ECG if BMI <16 or severe purging:

**Communication difficulties:**

**Is a translator/signer needed?**  Yes  No

If so, what language?