

Referral Form

Adult Eating Disorder Service – St Vincent's University Hospital

Wicklow, Dun Laoghaire, Dublin South East (CHO 6)

Referrer details

Referred by		Date of Referral	
Phone Number		Email Address	
Practice Address			

Patient details

Patient name			
Address (CHO 6 only)			
Date of birth		<input type="checkbox"/> under 18, please phone to discuss	
Phone number		Email Address	
Please be advised that if adequate information is not provided it will not be possible to process the referral			
Reason for referral (i.e. diagnosis, current issues)			
<input type="checkbox"/> Patient aware of referral	<input type="checkbox"/> Patient willing to attend service		
Previous/current eating disorder treatment (please include reports, etc if available)			
Weight (kg)	Height (cm)	BMI (weight in kg/height in m ²)	
Recent weight changes (include time period)			
Blood Pressure (+ postural change)	Heart Rate (+ postural change)	Temperature	

Please include a copy of recent blood results including FBC, WBC, U&Es, LFTs, bone profile, glucose, phosphate, and magnesium

ECG indicated (blood test abnormality, cardiac signs/symptoms, BMI is less than 15kg/m²) please attach a recent ECG

Eating disorder behaviours

	Yes	No	Additional info (frequency, duration, severity, recent change, etc)
Restricting intake			
Vomiting			
Bingeing			
Laxatives			
Over exercise			
Diet pills			
Alcohol misuse			
Drug misuse			

Other information

Medical history (incl. medical presentation secondary to eating disorder)	
Psychiatric history	
Medication	
Risk to self or others (e.g. self-harm, suicide, abuse, violence)	
Other relevant information	

Please send referrals to - Email: eatingdisorders@svhg.ie

or

Clinical Coordinator,
Adult Eating Disorder Service,
Elm Mount Lower,
St Vincent's Hospital,
Elm Park,
Dublin 4,
Tel: 01 2214627