**Client Referral Form**

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| **Full Name:** | **Date of Birth:**  |
| **Home Address:**  | **Email Address:** Consent given to contact by: Post and/or email: Post yes/no Email Yes/No |
| **Contact telephone numbers** (please mark preferred number to contact with a ‘P’). Mobile: Home: Consent given to contact by telephone: yes/noConsent given to leave voicemail: yes/no | **Current Weight:****Height**: **Ethnicity:** **Do you have type 1 diabetes?** Yes/No**Do you have any mobility issues?** Yes/No (it is necessary to climb a few steps to access building)  |
|  **GP details** GP’s name: Surgury Name: Address: Telephone Number: NHS No (if known): Consent to contact GP Yes/No(If no, please note we will be unable to proceed any further with this referral). | **Presenting Problem** (Please provide as much information as possible below regarding current eating behaviours, i.e. restricting, self-induced vomiting, binge eating. Purging, and any significant weight change within the last 3 months, together with details of any other mental health issues and any other services supporting you, i.e. Mental Health Team or Eating Disorder Service). |
| **How did you hear about Caraline?** **Have you ever been referred to the Community ED Service in Dunstable? If so please provide a date:**  | **Date of referral:** **Method of referral:** email/letter/telephone/fax |
| **To be completed by office staff -**  |  |
| Date added to database:  | Date added to portal:  |