**[](https://www.caraline.com/)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/no  Consent 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: |