**Feeding and Eating Disorders Service (FEDS) Referral Form**

Please note, we only accept referrals from **NHS Paediatricians and CAMHS clinicians.**

For further information, please read our referral criteria on the GOSH FEDS website.

**Incomplete forms and any missing information will likely result in a rejection.**

**In 2021, 25% of our referrals were rejected due to incomplete information.**

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| We are a **Tertiary National and Specialist Child and Adolescent Mental Health Service**. We take a Multi-Disciplinary Team (MDT) approach to feeding and eating difficulties, focusing on emotional, behavioural, and psychological aspects of eating difficulties and disorders. Where there are structural and/or medical concerns, this may not be the appropriate team. |

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| **Referring Date:** |

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| **Referrer and GP Information** |
| **Referrer Details:**  **Name:**  **Job title:**  **Address:**  **Telephone:**  **Email:** |
| **GP Details:**  **Name:**  **Address:**  **Telephone:** **Email:** |

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| **Patient Information** |
| **Name:**  **DOB:** **Age:**  **Ethnicity** **Sex/Gender:** **NHS No:**  **Address:**  **Parents/Guardians’ Names:**  **Home Telephone No:** **Mobile No**:    **Email:**  **Interpreter needed?** Yes/No If yes, what language?  **Is the family known to Social Care?**  Yes/No **Name of Social Worker:** |

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| **Request (please TICK ONE option only)** |
| Assessment for 2nd Opinion  Assessment and Advice/Recommendations  Assessment and Support/Intervention  ☐ Consultation to Local Professionals/Care Team |

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| **Reason for Referral** |
| Rationale for referral including why a referral to a National and Specialist Mental Health Service is necessary (eg why assessment and/or support cannot be delivered by local Services). |

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| **Presenting Problem** |
| Please provide details of the child or young person’s presenting problem with food or eating. Please include an account of their current food and fluid intake (eg a one day Food Diary). |

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| **Expectations and Motivation** |
| **Motivation of the Young Person:**  Please describe whether the young person seems motivated to make changes to their eating. Does the child or young person have any goals? Is the child bothered by their limited intake?  **Parental Expectation and Motivation:**  Please comment on the following: what are parental perspectives and expectations; what are they hoping from a referral to our team? |

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| **Physical Health Status** | |
| Please list any physical health conditions including gastroenterological conditions, disabilities, genetic conditions, or relevant medical information (eg allergies). | |
| **Symptoms** | |
| **Does the child have any of the following symptoms?** | **If yes, what has been done (including investigations)?** |
| Please tick all that are relevant.  Vomiting  Restricting meals  Diarrhoea  Bingeing  Constipation  Purging  Reflux  Body image concerns  Allergy (food)  Laxative use  Dysphagia  Over exercising  Recurrent chest infections  Limited dietary variety  Limited dietary amount | Please add further details **and include relevant reports**. |
| **Menstruation status (if applicable)** | **If have not started as expected, are irregular or have stopped, what has been done (including investigations)?** |
| Please tick relevant boxes.  Not started  Mostly regular  On and off  Stopped  N/A  Don’t know | Please also note whether there are signs of puberty and development? |
| **Weight and Growth** | |
| **Please note we DO NOT accept children with acute weight loss or faltering growth who require immediate medical and/or dietetic management. If the child’s weight for height is <80% we require that they are assessed and continue to remain under the care and review of their local paediatrician.**  **Weight (kg) and centile:**  **Height (cm) and centile:**  **Weight for height:**  Has the patient lost weight over the last month?  If yes, please elaborate (eg what weight loss, over what time frame).  Historical growth information (eg any known past measurements, including birth weight): | |
| **Other Relevant Medical or Physical Health Information (including Enteral Feeding)** | |
| Other relevant physical health information, including enteral feeding. If enteral feeding, please comment on whether this is current and/or historical, type (NG, gastrostomy, TPN), duration, and whether the child continued to eat and drink orally whilst tube fed. | |

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| **Psychiatric History** |
| **Current Diagnoses** |
| Please list any mental health, (neuro)developmental diagnoses and/or intellectual disabilities: |
| **Medication and Supplement History** |
| Current medications (including dosage):  Current nutritional supplements (eg multivitamins or oral nutritional supplements)  Any previously tried medications or nutritional supplements: |
| **Previous and Current Support** |
| Please describe any previous support the child, young person or family have received, including the type and duration of intervention. If known, please include details of engagement, if the intervention was helpful, and why the intervention or support ceased. **Please attach relevant reports alongside this form, failure to do so will result in a referral being rejected.** |

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| **Background and Further Information** |
| **Family History** |
| Composition of household/significant adults: |
| Siblings or other children in the household (names, ages, any difficulties): |
| Support network and wider social factors: |
| Family history of relevant medical or psychological conditions (eg neurodevelopmental diagnoses, mental health conditions, eating disorders, or gastroenterological conditions): |
| **Developmental Milestones (Expected or Delayed)** |
| Physical milestones and development (fine and gross motor skills):  Language and communication development:  Development of other skills (eg toilet training): |
| **Early Feeding History** |
| Bottle, breast, or combination feeding (including any early difficulties with feeding)?  Please describe any known information about the weaning process/early feeding history: |
| **Education History** |
| Name of school:  Type of provision (e.g., mainsteam/specialist):  Which year is the child in?:  School performance, including any specific learning difficulties or disabilities:  Any issues with regard to schooling (eg attendance, bullying)?  Does the child or young person have an EHCP?  Does the child or young person have any support in place at school for eating? |
| **Risk Assessment and Safeguarding** |
| **If the child or young person referred is dietetically or medically compromised, urgent medical stabilisation needs to be managed by local healthcare professionals.**  Please provide a risk rating of low, medium, or high. Please consider medical and dietetic risk and mental health risk (eg to self, to others, or from others):  Any safeguarding concerns?  Are the family known to social care?  *If yes, please provide the name and contact details below* |

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| **Names and Contact Information of Professionals** |
| **Care Coordinator** (who will be responsible in managing the care of child locally): |
| **Paediatrician:** |
| Education (eg Teacher / SENCO) Contact: |
| Dietitian: |
| Occupational Therapist: |
| Speech and Language Therapist: |
| Social Worker: |
| Other: |

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| **Consent and Checks** |
| ☐ Has the referral been discussed with the child or young person’s parent(s)/guardian(s)?  ☐ Have the child or young person’s parent(s)/guardian(s) agreed to a referral to the Feeding and Eating Disorder Service at GOSH and understand it is a referral to a Tertiary National and Specialist Child and Adolescent Mental Health Service?  ☐ If the child or young person is aged 10 years or above, has agreement from local CAMHS been provided?  ☐ Have you completed all sections of this referral form?  ☐ Have you included relevant supplemental reports alongside this referral (eg medical investigations, dietetic letters, and summaries/reports from those involved in the child’s care‑- psychologists, SLT and OT)? |
| **If you have answered yes to all of the above:** |
| Please return this form, attaching relevant reports, to the PAMHS team via secure nhs.net email: [gos-tr.PAMHS@nhs.net](mailto:gos-tr.PAMHS@nhs.net)  Contact number for Queries: 020 7405 9200 (ext. 5652) or 020 4829 8679 (ext. 5652). |
| **Thank you for taking the time to complete this referral.** |