CherishED Professional Referral Form

Referral Details

Date of Referral:

Referrer Name:

Profession:

Organisation:

Email:

Telephone:

Client Details

Full Name:

Date of Birth:

Address:

Telephone:

Email:

Preferred method of contact:

NHS Number (if known):

GP Practice:

GP Contact Details:

Emergency Contact (Name, Relationship and Telephone):

Reason for Referral

Please describe why you are referring this individual to CherishED Occupational Therapy:

Eating Disorder Information

Diagnosis (if applicable):

Date of diagnosis:

Current symptoms:

Duration of illness:

Relevant treatment history:

Current treatment providers:

Current medical monitoring arrangements:

Occupational Difficulties

Please indicate areas affected.

- ☐ Daily routines
- ☐ Personal care
- ☐ Meal preparation
- ☐ Shopping
- ☐ Work
- ☐ Education
- ☐ Relationships
- ☐ Social life
- ☐ Leisure
- ☐ Confidence
- ☐ Motivation
- ☐ Sensory experiences
- ☐ Managing emotions
- ☐ Identity
- ☐ Other

Please provide further detail:

Current Risk

Please indicate any known concerns.

- ☐ Medical instability
- ☐ Rapid weight loss
- ☐ Self-harm
- ☐ Suicidal thoughts
- ☐ Recent hospital admission
- ☐ Substance misuse
- ☐ Safeguarding concerns
- ☐ None known

Further information:

Current Physical Health Monitoring

Is the client currently monitored by a GP or specialist medical team?

- ☐ Yes
- ☐ No

If yes, please provide details:

Current Professionals Involved

GP:

Psychiatrist:

Psychologist:

Dietitian:

Community Mental Health Team:

Eating Disorder Service:

Other:

Goals for Occupational Therapy

How can occupational therapy support your client?

Relevant Reports Attached

- ☐ Clinic letter
- ☐ Risk assessment
- ☐ Medical summary
- ☐ Care plan
- ☐ Recent blood results (if appropriate)
- ☐ Other

Consent

- ☐ The client has consented to this referral.
- ☐ The client understands CherishED is an independent occupational therapy service.

Signature

Name

Date