Saint John of God Hospital
Stillorgan, Co. Dublin
Telephone: 01 221 1450

Saint John of God Hospital

REFERRAL FORM - EATING DISORDER RECOVERY CENTRE

Patient Name	
Date of Birth	
Telephone	
Address	

Insurance Cover	☐ Yes ☐ No
Insurance Provider	☐ VHI Healthcare ☐ Laya Healthcare ☐ Irish Life Health ☐ Garda Medical Aid ☐ Other, please specify:
Policy Number	

Referrer Name	
E-mail Address	
Telephone	
Address	
GP Details **(If different to referrer's details)**	

Service Required	☐ **Inpatient Admission** ☐ **Outpatient Treatment**
Referral Priority	☐ Urgent ☐ Priority ☐ Routine
If Urgent, please provide reason	
Previous Eating Disorder Treatment	

Current Weight (Kg):	**Height (m):**	**BMI :**
Blood Pressure:	Heart Rate:	Temperature:
Recent Weight Changes:		
Date of onset of current difficulties:		

Eating Disorder Behaviours

	YES	NO	Details
Restrictive eating			
Binging			
Purging			
Over exercise			
Laxative use			
Diuretic use			
Diet pills			

Past Psychiatric History

	YES	NO	Details
Previous engagement w/ CMHT or CAMHS			
Previous engagement w/ Psychotherapy or Counselling			
History of Self-Harm or Suicide Attempt			
Illicit Substance Use			
Alcohol Use			

Other Information

Medical History	
Current Medication	
Risk to Self / Others	
Other relevant Information	

Please attach the following:

- ✓ Copy of recent **blood results**
- ✓ (Including FBC, U&Es, LFTs, Bone profile, Glucose, Phosphate, Magnesium)
- ✓ Copy of **weight records**
- ✓ Recent **ECG**

Hep B

☐ Yes ☐ No

Hep C

☐ Yes ☐ No

HIV

☐ Yes ☐ No

Mobility Issues

☐ Yes - wheelchair user
☐ Yes - other, *please specify* Click to enter text
☐ No

Requires Assistance with ADLs

☐ Yes, *please specify* Click to enter text
☐ No

Allergy/Adverse Reactions (PLEASE TICK ONE BOX BELOW)

☐ Yes ☐ NKDA (No Known Drug Allergy)

IF YES: Please specify medicine(s) and nature of reaction

Click to enter text

Risk Assessment

Saint John of God Hospital strives to provide a safe therapeutic environment for every person under our care. One aspect of managing safety is the formulation of an individual and dynamic risk management plan for each patient, which is regularly discussed and updated as part of their overall care plan.

You can help us by letting us know about any concerns you may have in relation to your patient's safety, or about any risks you believe your patient may be exposed to. Your concern may be covered by one or more of the areas described below, or may involve additional areas. If you have additional or new concerns during your patient's stay in hospital, feel free to submit the risk assessment form as often as necessary. Please be aware that your comments may be discussed with/or accessed by your patient.

Please consider the following when completing the risk assessment (please explain in the spaces provided when box ticked). NB: Not completing this section in full may result in a delay to admission.

<table>
<tr><td>Vulnerability</td><td>☐ Physical illness
☐ Financial distress
☐ Harassment
☐ Decline in hygiene
☐ Confusion
☐ Exploitation</td><td>☐ Memory problems
☐ Disability
☐ Homelessness
☐ Stigmatization
☐ Poor self-care</td><td>☐ Poverty
☐ Abuse
☐ Falls
☐ Lack of supports</td><td>☐ Poor food intake
☐ Bullying
☐ Other, please specify
Click to enter text</td></tr>
<tr><td>Self-Harm /Suicide</td><td colspan="2">☐ Previous suicide attempt(s)
☐ Previous self-harm
☐ On-going suicidal ideation
☐ Suicidal gestures
☐ Hopelessness
☐ Major life-changes or challenges</td><td colspan="2">☐ Previous suicide in family/circle of friends

☐ Concern from others about risk of suicide/ deliberate self-harm

☐ Opinion of the referrer that there is a risk of suicide or deliberate self-harm

Other, please specify
Click to enter text</td></tr>
<tr><td rowspan="2">Mental Instability</td><td colspan="4">Intense and obvious symptoms of mental illness:</td></tr>
<tr><td>☐ Risk taking behaviours
☐ Bizarre behaviours
☐ Sexually disinhibited</td><td>☐ Overspending
☐ Anger/aggression
☐ Impulsivity</td><td colspan="2">☐ Increased alcohol/drug use
☐ Not following medical or legal advice
☐ Other, please specify
Click to enter text</td></tr>
<tr><td>Risk to Others</td><td colspan="2">☐ Recent/past history of violence
☐ Poor self-control when angry
☐ Antisocial tendencies
☐ Possession of/access to weapons
☐ Current thoughts, plans or symptoms of violence</td><td colspan="2">☐ Known risk to vulnerable adults/children
☐ Expressed concern from others about risk of violence
☐Current behaviour suggesting risk of violence
☐ Opinion of the referrer that there is a risk of violence
☐ Other, please specify</td></tr>
</table>

Does this person have any forensic history?

☐ Yes, please *provide details below* ☐ No

Click to enter text

Are any charges pending against this person?

☐ Yes, *please provide details below* ☐ No

Click to enter text

Form Completed By			
Name & Professional Registration Number	Click to enter text	Date	Click to enter date

✓

For Internal Use Only
Are any significant risk factors highlighted? ☐ Yes ☐ No
IF YES: Have these risk factors been discussed with the nurse in charge of the admitting suite?
☐ Yes Suite _____
Name of Nurse _____