Refer to Orri

To refer a patient/client, please fill out the referral form below and send it to: referrals@orri-uk.com

For urgent referrals, please call us on 0203 918 6340 between 9:30am – 5:30pm, Monday – Friday.

Please note that this form is secure, and the information will remain confidential within the Orri team.

Section 1 - The referrer

Please can we confirm some key information about you, the referrer:

First name*	Last name*

Title*	Profession *

Email*	Phone number*

Name of practice/organisation*

Address of practice/organisation*

Section 2 - Your referral

Please can we confirm some key information about the person you are referring to us:

First name	Last name

Date of birth	Phone number

Email	

Please confirm if we have **consent** to contact your patient/client to discuss how Orri could support them *(please tick)*:

Yes, my patient/client has given consent to be contacted	☐
No, my patient/client hasn't given consent to be contacted	☐

If the point of contact is someone **other** than the patient/client (for example, a parent, guardian, or partner), please provide their name, contact details, and confirm their relationship to the person you are referring.

Name	
Mobile phone number	
Email	
Relationship to patient/client	

Section 3 – Clinical information

Does the client/patient have an eating disorder diagnosis? (*please tick)*:

Yes	
No	

If yes, please confirm the diagnosis (*please tick)*:

Restrictive Eating/Anorexia	
Bingeing and Purging/Bulimia	
Binge Eating or Compulsive Eating	
Selective Eating/ARFID	
Orthorexia	
Anorexia Athletica	
OSFED (Other Specified Feeding and Eating Disorder	
Other	
Unsure	

Does the patient/client exhibit any of the behaviours listed below? (*please tick)*

Food restriction	
Excessive exercise	
Self-induced vomiting	
Use of laxatives	
Use of diuretics	
Self-harm	
Other	

Has the patient/client ever misused drugs or alcohol (*please tick)*?

Yes	
No	
Unsure	

Is the patient/client taking any prescription medication currently? If yes, please detail

Please share a brief history of the patient/client's eating disorder (age of onset, length of time with an eating disorder)

Does the patient/client have a history of suicidal behaviour or self-harm?

Has your patient/client had previous treatment for their eating disorder? If so, please provide any information and dates you may have.

Please share the length of time you have been involved with this patient/client (weeks/months/years).

Section 4 – Our next steps

Your referral will be reviewed by our clinical team. If the team feel that Orri can support your patient/client, assuming we have consent, we will contact them directly (or the person who has been identified on this form as the person to contact) to arrange an in-depth, 90-minute assessment.

You will be notified by email about the outcome of your referral and whether the person you have referred will be commencing treatment at Orri.

Please email the completed form to: referrals@orri-uk.com