**Eating Disorder Service Example Transition Plan**

Name:

NHS No:

Date:

Date of Birth:

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| AMHS Transition Worker: | Tel: |
| CAMHS Transition Worker: | Tel: |

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| Proposed date of completed Transition (If known): |
| Views of Patient: |
| Views of Family/Carer: |
| Views of CAMHS Transition Worker: (To include treatment to be completed prior to transition and timeframe) |
| Views of AMHS Transition Worker: (To include treatment to be started) |
| Safeguarding considerations: |
| Physical health needs and monitoring arrangements: |
| Action Plan: |
| Transition plan review date: |
| Signed by: Copies to: |
| AMHS Transition Worker: |
| CAMHS Transition Worker: |
| Patient: |