The UNC Center of Excellence for Eating Disorders (UNC-CEED)

School of Medicine, Department of Psychiatry

Treatment Referral Form

Phone: 984.974.3834 Fax: 984.974.3779

Thank you for your interest in submitting a referral. Our Intake Coordinator will review your information with the clinical treatment team and respond as soon as possible. Missing, incomplete, or illegible information will delay the processing of your referral. **Please complete the subsequent pages and include copies of the following supplemental documents**, as available:

- Recent lab results and EKG report
- Relevant H&P notes
- Psychiatric Evaluation
- Growth Charts (for patients under age 19)

Patient Information

Patient Name: _____ **Date of Referral:** ___/___/___
First Middle Last

Patient DOB: ___/___/___ **Age** _____ **UNC Medical Record #** _____

Sex: ☐ **M** ☐ **F** **Race:** _____ **Relationship Status**: _____ **SSN:** _____

Is patient currently a student? ☐ **Y** ☐ **N** School: _____

If Patient is a Minor: Mother's Name: _____ Date of Birth: ___/___/___

Father's Name: _____ Date of Birth: ___/___/___

Mailing Address: _____

_____
City State Zip County

Preferred Email Address for Referral Related Communication**:** _____

Home Phone: (___) _____ *May we leave a message at this number?* ☐ **Y** ☐ **N**

Cell Phone: (___) _____ *May we leave a message at this number?* ☐ **Y** ☐ **N**

Other Phone: (___) _____ *May we leave a message at this number?* ☐ **Y** ☐ **N**

Level of Care Requested: ☐ Inpatient ☐ Partial Hospitalization ☐ Outpatient ☐ Group

Is the patient interested in eating disorders treatment research studies, if eligible? ☐ No ☐ Yes

For Intake Office Use Only: BMI: _____ IBW: _____ %IBW: _____

Authorization for the Exchange of Protected Health Information

To be completed with patient or authorized legal guardian/representative

By way of authorizing this referral, I also authorize the UNC Center of Excellence for Eating Disorders (UNC-CEED) to communicate with my health care provider(s) regarding this referral and any related treatment information. State and federal privacy laws do not require patient authorization for the release of protected health information when the release is for treatment or continued patient care. However, it is the practice of the UNC-CEED to request patient consent, and, by signing below, I consent to the disclosure of my protected health information for treatment purposes.

State and federal privacy laws require that I consent to the disclosure of my protected health information to family members, except if I am a minor or do not have decision-making capacity. The UNC-CEED requests my consent to communicate with relevant family members regarding this referral, and by providing names and contact information for my family members (below), I am authorizing the UNC-CEED to communicate with them about this referral.

Family Members:

- ☐ Parent (Name: _____ Phone: _____)
- ☐ Spouse (Name: _____ Phone: _____)
- ☐ Other (Name: _____ Phone: _____)
- ☐ Other (Name: _____ Phone: _____)

-OR-

☐ I do not consent to the UNC-CEED contacting my family members regarding this referral.

I understand that this authorization for the exchange of protected health information applies to this referral only and that it will not apply to the release of protected health information related to any treatment that may result from this referral.

I understand that I may revoke this authorization at any time by writing to the UNC-CEED Intake Coordinator. The revocation will not apply to information PHI that has already been released in response to this authorization. I have been informed and understand that information disclosed to non-health care providers pursuant to this Authorization may be redisclosed by the recipient of such information and that, once disclosed, the privacy of the information may no longer be protected under federal privacy laws. Unless otherwise revoked, this authorization will automatically expire one year from the date of signature.

_____ ____/____/____

Signature of Patient or Legal Guardian *Date*

Insurance Information

Primary Insurance Company

Insurance Company Name: _____

Insurance Company Phone #: _____

Group #: _____

Patient's Policy/ID #: _____

Patient's Name: _____

Patient's Date of Birth: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Secondary Insurance Company

Insurance Company Name: _____

Insurance Company Phone #: _____

Group #: _____

Patient's Policy/ID #: _____

Patient's Name: _____

Patient's Date of Birth: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Please include clear/legible copies of all insurance cards (front and back) including any secondary insurances.

Guarantor Information

Guarantor Name: _____

Guarantor Date of Birth: _____ Guarantor Social Security #: _____

Guarantor Address: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed

Guarantor Employer: _____

Guarantor Employer Address: _____

Referring Provider Information

☐ Primary Care MD ☐ Psychiatrist ☐ Dietitian ☐ Psychologist/LPC/LCSW ☐ Other _____

Name: _____ **Work Phone:** (____) _____

Email Address: _____ **Work Fax:** (____) _____

Facility Name & Location: _____
Name Address City State Zip

How did you hear about the UNC Center of Excellence for Eating Disorders?

☐ Physician ☐ Therapist ☐ Dietitian ☐ Community Presentation ☐ UNC Website

☐ Media (TV, News Article, Advertisement) ☐ Other _____

Diagnosis Information

Axis I (psychiatric diagnoses) _____

Axis II (personality/developmental) _____

Axis III (medical diagnoses) _____

Axis IV (psychosocial stressors) _____

Axis V (GAF) _____

Presenting Symptoms:

☐ Binge Eating: _____ times per _____

☐ Vomiting: _____ times per _____

☐ Laxatives: _____ times per _____

☐ Diuretics/Diet Pills: _____ times per _____

☐ Exercise: _____ times per _____

Current Height: _____

Current Weight: _____

Approx. current daily caloric intake:

_____

Recent Weight Loss?

☐ **Yes –** Amount of weight lost over what time period: _____

☐ **No –** Length of time maintaining current weight: _____

Is patient monitored medically by a physician? ☐ **No** ☐ **Yes** If Yes – How often? _____

Name & Phone _____
(if different from referring provider)

***PROVIDER**: Please include any additional information (such as notes, evaluation, a letter, etc.) necessary to help us understand your goals in making this referral at this time (e.g., specific concerns or needs).*

Medical Problems and Treatment:

Prior and Current Outpatient Treatment:

Prior and Current Inpatient Treatment:

If currently in a facility, reason for admission:

Medication History (medication, outcomes)**:**

Current Medications:

Substance Use/Abuse:

Current Living Arrangements:

Suicidality (describe, other than starvation)**:**

Additional pertinent information (family history, etc.)**:**

Please indicate which supplemental materials you are including with this referral:

☐ Lab work ☐ EKG Report ☐ Psychiatric Evaluation ☐ Growth Charts ☐ H&P notes

Please fax this completed form and supplemental materials to our intake office at 984-974-3779.
Thank you!