The UNC Center of Excellence for Eating Disorders
Department of Psychiatry
101 Manning Drive, CB#7160
Chapel Hill, NC 27599-7160
984-974-5217

Thank you for your interest in submitting a referral. Our intake team will review your information and respond as soon as possible. Please complete the subsequent pages. Missing, incomplete, or illegible information will delay the processing of your referral.

Referral Form

Date of referral

Patient name

Patient DOB

SSN

Sex assigned at birth

- ◯ Female
- ◯ Male
- ◯ Prefer not to say

Gender identity

- ◯ Woman
- ◯ Man
- ◯ Non-binary
- ◯ Prefer not to say

Race

- ◯ American Indian or Alaska Native
- ◯ Asian
- ◯ Black or African American
- ◯ Hispanic or Latino
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ White
- ◯ Multi-racial
- ◯ Prefer not to say

Preferred language

- ◯ English
- ◯ Spanish
- ◯ Other

Is the patient a UNC student or UNC employee?

- ◯ Yes
- ◯ No

Pronouns

- ◯ She/her
- ◯ He/him
- ◯ They/them
- ◯ Other

If patient is a minor, please provide name and phone number of parent(s)/legal guardian(s).

Name

Phone number

Name

Phone number

Mailing address

Email address

Preferred phone number

May we leave a message at this phone number?

- ◯ Yes
- ◯ No

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 healthcare 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 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 member, except if I am a minor or do not have decision-making capacity. 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 UNC CEED to communicate with them about this referral.

Name	Relationship	Phone number
Name	Relationship	Phone number
Name	Relationship	Phone number
Name	Relationship	Phone number

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. The revocation will not apply to information that has already been released in response to this authorization. I have been informed and understand that information disclosed to non-healthcare 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 #

Subscriber Name

Subscriber DOB

Secondary Insurance Company

Insurance Company Name

Insurance Company Phone #

Group #

Patient's Policy/ID #

Subscriber Name

Subscriber DOB

Guarantor Information

Guarantor Name:

Guarantor DOB:

Guarantor SSN:

Guarantor address:

Guarantor employment status

- ◯ Full time
- ◯ Part time
- ◯ Unemployed

Guarantor Employer:

Guarantor Employer Address:

Referring Provider Information

PCP/Peds ☐ **Psychiatrist** ☐ **Psychologist/therapist** ☐

Dietician ☐ **Other (specify)** _____

Name _____ **Work phone** _____

Email address _____ **Work fax** _____

Facility name and location _____

Referral Information

Weight status BMI or peds BMI percentile _____

Weight loss ◯ Yes ◯ No **Amount and timeframe of weight loss** (if applicable) _____

Medical instability

Check all that apply

- ☐ Bradycardia
- ☐ Tachycardia
- ☐ Hypothermia
- ☐ Hypotension
- ☐ EKG abnormalities
- ☐ Lab abnormalities
- ☐ N/A

Eating disorder symptoms

Check all that apply

- ☐ Binge eating
- ☐ Restrictive/selective eating
- ☐ Self-induced vomiting
- ☐ Compulsive exercise
- ☐ Laxative/diuretic/diet pill abuse
- ☐ Other

Reason for evaluation _____

Disclaimer: CEED can conduct a comprehensive evaluation, but cannot guarantee ongoing management/treatment.

☐ I understand

Please include copies of any of the below supplemental documents, as available

- ☐ Recent lab results and EKG
- ☐ Psychiatric evaluation
- ☐ Relevant H&P notes
- ☐ Growth charts (for patients under age 19)

Please send this completed form to the UNC Department of Psychiatry.

Phone: 984-974-5217 **Fax: 984-974-9646**