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

CEED Referral Form

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.

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

Patient Information

Date of Referral: _____ **Name:** _____ **Date of Birth:** _____

Social Security Number: _____ **UNC Medical Record Number** (if applicable)**:** _____

Sex assigned at birth:
- ☐ Female
- ☐ Male
- ☐ Prefer not to say

Gender identity:
- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ Prefer not to say

Pronouns:
- ☐ She/her
- ☐ He/him
- ☐ They/them
- ☐ Other

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: _____ **Is the patient a UNC student or employee?:** ◯ Yes ◯ No

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

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Mailing address: _____
Street Address

_____
City, State, Zip, County

Email address: _____

Best phone #: _____ **May we leave a message at this number?** ◯ Yes ◯ No

Name and contact information for patient's primary care provider/pediatrician: _____

_____

_____

Authorization for the Exchange of Protected Health Information

To be completed by 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.

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 or patient or legal guardian Date

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984-974-5217
Phone number

984-974-9646
Fax

Insurance Information

Please upload a photocopy of the patient's insurance card with this form.
Insurance information is required to schedule an evaluation.

☐Self-pay ☐Charity care

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Referring Provider Information

Referring provider type (check one):

☐ Primary care provider (PCP) ☐ Pediatrician ☐ Psychologist/therapist

☐ Dietician ☐ Parent/guardian ☐ Self-referred

☐ Other (specify): _____

If a healthcare provider referral:

Provider name: _____ Facility name: _____

Facility address: _____
Street Address

_____
City, State, Zip, County

Work phone: _____ Work fax: _____

Referral Information

Weight: _____ **Height:** _____ **BMI:** _____ **Weight loss:** ◯ Yes ◯ No
If yes, specify amount and timeframe: _____

Medical instability
☐ Bradycardia
☐ Tachycardia
☐ Hypothermia
☐ Hypotension
☐ EKG abnormalities
☐ Lab abnormalities
☐ N/A

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

Reason for evaluation: _____

Level of care requested: ◯ Outpatient ◯ Inpatient **Please call the Inpatient Admissions Coordinator at 984-974-3834 with any questions.**

If inpatient requested, the below must be faxed to the Inpatient Admissions Coordinator at 984-974-3779.		
☐ Most recent progress note from the referring provider		☐ Most recent progress note from PCP/pediatrician
☐ Most recent labs	☐ EKG	☐ Growth charts (for patients age ≤ 19 years)

Please send this completed form to the UNC Center of Excellence for Eating Disorders at the fax number listed below. Thank you!

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