EXTERNAL REFERRAL FORM FOR SERVICES

☐ **EATING DISORDER INPATIENT HOSPITALIZATION**

☐ **MINDFUL TRANSITIONS EATING DISORDERS ADULT PARTIAL HOSPITALIZATION PROGRAM**

☐ **INTENSIVE OUTPATIENT EATING DISORDER PROGRAM**

Lindner Center of HOPE | UC Health

4075 Old Western Row Road, Cincinnati, OH 45040

Thank you for referring your patients to Lindner Center of HOPE. Please complete this form, then print and **fax to (513) 536-0509.** Please be thorough, as this form will allow us to have all the information required to get the patient started in PHP, IOP or Inpatient Treatment.

If you have questions, please contact us at: (513) 536-0538 **Date of Referral:**

Demographic Information

Name of Patient:		DOB:	
Address:			
Best Contact #:		Email:	

Insurance Information

Insurance Co.:			
ID#:		Group #:	
Subscriber Name:		DOB:	
# To Verify Benefits:			

Referral Source

Referrer Name:	Length of Treatment Relationship:		
Agency			
Phone/Fax		Email:	

How long have you had a clinical relationship with this patient?

Clinical Information

***Please attach CMP, CBC, Magnesium, Phosphorous, EKG with interpretation, and any other relevant testing (must be done 1 week prior to referral date.)**

Ht: Wt: BMI: Orthostatic VS: (sitting) (standing) When did ED start:

Recent weight changes: Food allergies/preferences:

Clinical Goals for

Primary Goal:	
Secondary Goal:	

Current Diagnosis

I:	
II:	
III:	
IV:	
V:	

ED Behaviors and frequency

Binge:

Purge:

Restrict:

Exercise:

Laxative, diuretic, fat absorber, stimulant use:

Other: (body checking, weighing, etc)
Previous Mental Health Treatment Programs (include ED, general mental health, substance)
Substance Abuse History
Alcohol:
Tobacco:
Drugs:
Caffeine:
Current Medication (Name, dose and frequency)
Medication allergies and adverse reactions:
Do you feel patient is medication compliant?
Are you looking for medication adjustments/recommendations?
If so, preferred communication of changes/recommendations?
Past Medical History
Any other pertinent social or trauma information
Current Outpatient Treatment (Please include intended prescriber post PHP/IOP/IP.)

Psychiatrist:		Dietician:	
Therapist:		Other:	
Primary Care:			

Comments/Other Relevant

LCOH Program Staff Approval or Decline (If not appropriate for PHP or IOP, should they be considered for a higher level of care?):

☐ Approve: Inpatient _____ PHP _____ IOP _____ Per _____

☐ Decline: Reason and Plan _____

Staff Signature: _____Date/Time: _____