LINDNER CENTER OF HOPE

EXTERNAL REFERRAL FORM FOR SERVICES

- ☐ **EATING DISORDER INPATIENT HOSPITALIZATION**
- ☐ **MINDFUL TRANSITIONS EATING DISORDERS ADULT PARTIAL HOSPITALIZATION PROGRAM**
- ☐ **INTENSIVE OUTPATIENT EATING DISORDER PROGRAM**

Thank you for referring your patient to Lindner Center of HOPE

Print and fax completed form 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 Inpatient Treatment, PHP or IOP

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

Demographic Information	
Date of Referral:	
Name of Patient:	
DOB:	
Address:	
Best Contact #:	
Email:	
Insurance Information	
Insurance Company: ID number	
Subscriber:	
Subscriber DOB:	
Referral Source	
Referrer Name:	
Agency:	
Length of Treatment Relationship:	
Phone/Fax:	
Email:	
Preferred contact method for communication:	

Clinical Information
Please FAX results of the following to 513-536-0509
Labs: CMP, CBC w/differential, Magnesium, Phosphorous **(must be done within one week of referral date)**
EKG with interpretation **(must be done within one week of referral date)**
Height:
Weight:
BMI:
Temperature:
Orthostatic Blood Pressure: Sitting: _____ Standing: _____

LINDNER CENTER OF HOPE

Orthostatic Heart Rate: Sitting: _____ Standing: _____
Any weight loss/gain in past: 2 weeks- 1 month- 2 months- 6 months-
Reason for Referral:
When did eating disorder start?
Current Psychiatric Diagnoses:
Medication allergies and adverse reactions:
Past Medical History and Food Allergies/Sensitivities:
List of Medications and doses:
Referral from outside facility
Previous Mental Health Treatment Programs (include ED, general mental health, substance): **History of medical hospitalization (last 6 months):** **Were any of these related to eating disorders-Y/N? If yes, please describe-**
Within the last month any-
Syncope:
Lab changes:
Electrolyte imbalance:
Chest pain:
Dehydration:
Any lifetime history of refeeding syndrome?
Is the patient on tube feeds: if yes, what type? **Bolus? Continuous? Total volume received in 24hrs:**
Is the patient Independent with activities of daily living?
If the patient is not independent, explain what the patient's needs are:
Does this patient have any disabilities for which they would require assistance (i.e. difficulties with ambulation, hearing loss, vision loss, blindness, need for translator, learning challenges?)
Current Outpatient Treatment (Please include intended prescriber post IP/PHP/IOP)
Psychiatrist:
Therapist:
Primary Care:
Dietician: