LINDNER CENTER OF HOPE

EXTERNAL REFERRAL FORM FOR SERVICES

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

Thank you for referring your patient to the 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:	
Subscriber:	
Subscriber DOB:	
Referral Source	
Referrer Name:	
Agency:	
Length of Treatment Relationship:	
Phone/Fax:	
Email:	

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: _____ Orthostatic Heart Rate: Sitting: _____ Standing: _____

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Reason for Referral:
Eating Disorder Behaviors & Frequency: Self-induced vomiting: Restriction: Bingeing: Exercise, including pacing: Laxative misuse: Diuretic misuse: Other product misuse such as GLP-1 misuse, fat absorbers, etc.: Stimulant or caffeine misuse: Other: (body checking, weighing, etc.)
When did the eating disorder start?
Any weight loss/gain in the past: 2 weeks- 1 month- 2 months- 6 months-

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Within the last month any- Syncope: Lab Changes: Electrolyte imbalances: 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:
Current Psychiatric Diagnoses:
Medication allergies and adverse reactions:
Food allergies or sensitivities:
List of medications and doses:
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 and/or intended team post Inpatient treatment/PHP/IOP
Psychiatrist:
Therapist:
Primary Care:
Dietician: