

The Eating Disorders Treatment Center

AT RIVER OAKS HOSPITAL

Date: _____

Referral Contact: _____ Relation to Patient: _____

Facility Name: _____ Type of Facility (medical or psych): _____

Full Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Is patient currently hospitalized? _____ Since When? _____

Why? _____

Who is the attending physician and contact number? _____

Patient Name: _____

Full Address _____ City _____ State: _____ Zip: _____

Phone: _____ Pt. Age: _____ Pt. D.O.B. _____

Pt Soc Sec# _____ Name of Insured: _____

Insurance Company: _____ Policy # _____

Insured SS# _____ Benefits ph#: _____

** Outpatient Team: (this is referring to providers outside the inpatient setting)

PCP Name _____ Phone # _____

Psychiatrist Name _____ Phone # _____

Therapist Name _____ Phone # _____

Nutritionist Name _____ Phone# _____

Is patient attending outpatient sessions regularly? _____

Reason for Referral: Please circle all that apply and describe briefly.

Family Requests Admit - Therapist Requests Admit - Failure of Outpatient Therapy - Failure of Inpatient Therapy

Other: _____

Clinical Data: When did ED first start? _____

Height: _____ Weight: _____ BMI: _____ Is this an increase or decrease, over what period of time? _____

Highest Weight? _____ When? _____

Lowest Weight? _____ When? _____

Behaviors: What does the pt. eat on a typical day? _____

Restricts: Y N Estimated caloric intake? _____

Binges: Y N # Binges/day or/week: _____

Purges Y N # Purges/day or/week: _____

Circle All that Apply:

Vomiting - Laxatives - Diet Pills - Diuretics - Ipecac - Enemas - Exercise

Medical and Psychiatric Information:

Current/Past Medical Conditions- Please list: _____

_____ Last Menses?

Current Psychiatric Information and Diagnoses: _____

Current Medical & Psychiatric Medications: _____

Substance Abuse or Dependence? _____ What?

How much? _____

Does pt. smoke? Y N If so, please we aware that we are a **NON-SMOKING** facility.

If pt. is not currently using any substances, is there a history? _____

Sexual/Physical Trauma? Y N _____

Self Injurious Behavior Y N _____

Has patient been Inpatient in the last 60 days? _____ From: _____ To: _____

Why? _____

Please list and describe any further hospitalizations, and include reason for admission and date:

Additional Information: _____

Has pt. ever left AMA from a hospitalization? Y N _____

Has this pt. ever been tube fed? Y N _____

Is patient voluntary? Y N _____

Does pt. have a peg tube? Y N _____

***If patient is currently inpatient please fax psychiatric evaluation, most recent progress notes and any other pertinent information from outpatient treatment or any other hospitalizations.

** Please Note: We are a non-smoking facility

* Please see following list of lab work that will be required (it must be within the last two weeks)

Important:

*** IF PATIENT IS CURRENTLY INPATIENT PLEASE FAX PSYCHIATRIC
EVALUATION AND MOST RECENT PROGRESS NOTES**

PRE ADMIT LAB REQUEST FORM

**Please print your name, check your diagnosis, and bring this lab request
to your Treating Physician or Local Lab**

Name: _____

Diagnosis: Check One

Anorexia Nervosa 307.1

Bulimia Nervosa 307.51

Eating Disorder NOS 307.50

Dear Doctor and/or Laboratory Staff:

Please draw the following Pre Admit labs and FAX the results to River Oaks Hospital
Eating Disorders Treatment Center

Fax # 504-733-3229

CBC

CMP

Phosphorous

Magnesium

EKG