Chrysalis
Center for Counseling
and Eating Disorder Treatment

Intensive Outpatient Program Referral Form

3240 Burnt Mill Drive ◇ Suite 1 ◇ Wilmington, NC 28403 ◇ Tel: 910-790-9500 ◇ Fax: 910-796-8111

Please fill out the following:

Client Name:_____ Date: _____

SS#:_____ DOB:_____ Sex: M F

Referring provider name, facility & mailing address: _____

_____

Phone: _____ Fax: _____ Email: _____

Type & Frequency of Current Treatment: _____

Eating Disorder/Mental Health History:

Current Diagnosis: _____

_____

_____

Current Symptoms: _____

_____

_____

Height & Weight:_____

Approximate daily calorie intake:_____

Recent weight loss and/or gain? (how much and over what time period): _____

_____

Medical problems and treatment: _____

_____

Prior and current mental health/eating disorder treatment: _____

_____

_____

Current medications (including dose and frequency): _____

_____

This information has been disclosed to you from records whose confidentiality is protected by confidentiality provisions of most states' law and applicable federal law. Under such law, you are prohibited from making any further disclosure of these records without the specific written consent of the person to whom they pertain or as otherwise specifically required or permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal regulations under 42 CFR Part 2 restrict any use of the confidential information to criminally investigate or prosecute any alcohol or drug abuse patients.

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Client Name: _____

Substance use/abuse (history and current): _____

_____

Risk assessment (suicidality, self-injury): _____

_____

Current living situation: _____

Requirements for IOP Admission:

Is the patient ambulatory? Yes No
Details: _____

_____

Can the patient manage one's own medications? Yes No
Details: _____

_____

Are there any limitations on physical activities? Yes No
Details: _____

_____

Is the patient free from communicable diseases? Yes No
If no, can the patient still be admitted with necessary precautions to the intensive outpatient program? Yes No
Details: _____

_____

Medical Screening (see also Physical Exam section, p. 4)

Every client is required to undergo a physical/medical health screening prior to admission with a qualified medical professional within two weeks of expected admission date that includes:

- Physical Exam including blind weight and vital signs (see also p. 4)
- EKG
- Lab tests - urinalysis, CBC, complete metabolic profile, serum magnesium, thyroid screening, etc.
- Medications
- Diagnosis(es).

*Any client with significant co-occurring medical issues will require medical clearance from their doctor verifying that they are safe to be in the program. The information will be reviewed by our staff prior to admission.

History of communicable diseases (If yes, please provide details): Yes No
Details: _____

Are there additional assessments needed? Yes No
Details: _____

Are there any medical/psychiatric/medication instructions? Yes No
Details: _____

Allergies: _____

_____

Client Name: _____

Primary Insurance Information (please include information on family member whose insurance you are covered by, if applicable):

Insurance Plan Name: _____

Subscriber Number or Member ID Number: _____

Group Number: _____

Employer's Name: _____

Client's Relationship to Policy Holder: _____

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address, Phone Number, Social Security Number and Birth Date: _____

_____

Secondary Insurance Information (If applicable):

Insurance Plan Name: _____

Subscriber Number or Member ID Number: _____

Group Number: _____

Employer's Name: _____

Client's Relationship to Policy Holder: _____

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address, Phone Number, Social Security Number and Birth Date: _____

_____

Additional information/comments: _____

_____

_____

_____

_____

_____

_____

Please indicate the materials you are including with this referral:

- ☐ Physical Exam (if not included on p. 4)
- ☐ Lab work
- ☐ EKG Report
- ☐ Growth Chart
- ☐ Meal Plan
- ☐ Psychiatric Evaluation
- ☐ Current Treatment Plan
- ☐ H&P Notes
- ☐ Other: _____

Provider Signature: _____ Date: _____

Client Name: _____

Physical Exam

Height: _____ft_____in (**Blind**) Weight_____lbs. BMI_____

	Lying	Standing
Blood pressure: **(orthostatic)**	_____/_____	_____/_____
Pulse**: (orthostatic)**	_____	_____

RR: _____ Temp: _____

HEENT: _____

_____

Dental: _____

Thyroid: _____

Chest/Lungs: _____

_____

Breasts:_____

Heart:_____

_____

Abdomen:_____

_____

Pelvic/Rectal:_____

_____

Skin/Hair/Nails:_____

Musculoskeletal:_____

Neurological:_____

Extremities/Edema:_____

_____

The following tests are **required** prior to the patient's admission; **please forward copies:**

- **Documentation of specific allergen testing is required for food allergies if exclusion is recommended.**
- Submission of patient's growth chart is **strongly encouraged**.
- CBC with differential
- Chemistry panel comprehensive
- TSH, T3, Total T4
- Amylase, Lipase
- Magnesium
- Phosphorous
- Hepatitis screen- A
- Urine HCG
- EKG
- Vit D, Vit B12
- Drug Toxicology Screen
- PPD (one step)

I hereby certify that _____*is medically stable and meets all requirements for admission to an intensive outpatient program.*

Physician Name & Business Name: _____

Physician Signature: _____ Date: _____

Office Address: _____

_____