



Chrysalis

Center for Counseling
and Eating Disorder Treatment

Intensive Outpatient Program

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

IOP REFERRAL FORM - CLINICIAN

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/gain? (how much and over what time period): _____

Medical problems and treatment: _____

Prior and current mental health/ED treatment: _____

Current medications (including dose and frequency): _____

Client Name: _____

Substance use/abuse: _____

Risk assessment (SI, SIB, etc.): _____

Current living situation: _____

Requirements for IOP Admission:

Is the patient ambulatory? Yes No

Details: _____

Can the patient manage her/his own medications? Yes No

Details: _____

Are there any limitations on physical activities? Yes No

Details: _____

Are there additional assessments needed? Yes No

Details: _____

Are there any medical/psychiatric/medication instructions? Yes No

Details: _____

Allergies: _____

Medical Screening (see also IOP Referral Form - Physician)

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
- EKG
- Lab tests - urinalysis, CBC, complete metabolic profile, serum magnesium, thyroid screening, etc.,
- Medications
- Diagnosis(es)
- Documentation of specific allergen testing is required for food allergies if exclusion is recommended

*Any client with significant eating disorder symptoms (weight below 80% of IBW, medical complications of malnutrition or purging, etc.) will require medical clearance from their doctor verifying that they are safe to be in the program.

Please indicate the materials you are including with this referral:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Physical Exam (or Medical Referral Form) | <input type="checkbox"/> Growth Chart | <input type="checkbox"/> H&P Notes |
| <input type="checkbox"/> Lab work | <input type="checkbox"/> Meal Plan | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> EKG Report | <input type="checkbox"/> Psychiatric Evaluation | |
| | <input type="checkbox"/> Current Treatment Plan | |

CHRYSALIS CENTER IOP REFERRAL FORM

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: _____

Provider Signature: _____

Date: _____