Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

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

IOP Referral Form - Clinician

Client Name:_____ SS#:_____

DOB:_____ Gender: 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:

- ☐ Physical Exam (or Medical Referral Form)
- ☐ Lab work
- ☐ EKG Report
- ☐ Growth Chart
- ☐ Meal Plan
- ☐ Psychiatric Evaluation
- ☐ Current Treatment Plan
- ☐ H&P Notes
- ☐ Other: _____

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: _____