



1525 River Oaks Road West
New Orleans, LA 70123

For Admissions please email the referral form to:
riveroaksspecialty@uhsinc.com

For all questions please contact us at:
504-734-1740

Date: _____

*Submit copies of the front and back of all medical insurance cards and the patient's driver's license or I.D. card.
Forms submitted without copies of insurance cards cannot be reviewed until all information is provided.*

Forms to be completed by clinician.

If currently inpatient, psychiatric evaluation must be submitted.

If patient has been discharged within 30 days, discharge summary is required.

REFERRING CLINICIAN: _____ **Credentials:** _____

Relationship to Patient: _____ Facility: _____

Phone: _____ Fax: _____ E-mail: _____

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

Reason for Referral: _____

PATIENT NAME: _____ **Age:** _____ **DOB:** _____

SSN: _____ Phone: _____ E-mail: _____

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

Living Situation: _____

Is patient currently hospitalized? Yes No If yes, since ___/___/___ Facility? _____

Attending Physician: _____ Phone: _____

Inpatient within the last 60 days? Yes No If yes, describe: _____

Has patient been to River Oaks before? Yes No If yes, when? _____

Prior eating disorder hospitalizations (Include facility, date, and length of stay): _____

Has patient ever left AMA: Yes No If yes, why/when? _____

Legal issues and history of incarceration: _____

Currently Pregnant? Yes No Is Patient Ambulatory? Yes No

Accommodations: Wheel Chair Cane Walker Shower Chair

Other special needs (e.g. CPAP machine, insulin pump, etc.) _____

Is patient diagnosed with celiac disease? If so, is it currently being treated? _____

Does the patient have a Casein Allergy and/or is a vegetarian? _____

Notable Medical History: _____

OUTPATIENT TEAM

PCP: _____ Phone: _____ E-mail: _____

Psychiatrist: _____ Phone: _____ E-mail: _____

Therapist: _____ Phone: _____ E-mail: _____

Nutritionist: _____ Phone: _____ E-mail: _____

Attending outpatient sessions regularly? Yes No How often? _____

Current psychiatric diagnoses: Anorexia Bulimia ED, NOS BPD DID Bipolar
PTSD GAD MDD Other: _____

What age did ED begin? _____ Height: _____ Weight: _____ BMI: _____, as of: _____ Last menses: _____

Weight: Increase Decrease LBS: _____ Over what period of time? _____

Restricting: Yes No Estimated daily caloric intake: _____

Binging: Yes No Number of binges per day or week: _____

Purging:	Vomiting	Laxatives	Diet Pills	Diuretics	Ipecac	Enemas	Exercise
# of times	/day	/day	/day	/day	/day	/day	/day

Additional Information: _____

Is patient currently eating solid food: Yes No Currently on feeding tube: Yes No

Does patient smoke? Yes No If so, please be aware that this program **DOES NOT** allow smoking.

Patient's Level of Motivation: Good Fair Poor

ALL MEDICATIONS (Attach separate sheet if necessary)

Name	Dose	Frequency	Indication/Compliance

SUBSTANCE USE	How Much	Frequency	Last Use
ETOH	_____	_____	_____
THC	_____	_____	_____
OPIATES	_____	_____	_____
BENZOS	_____	_____	_____
OTHER	_____	_____	_____

TRAUMA HISTORY: Sexual Physical Emotional Age _____ Relationship to perpetrator: _____

Present symptoms: Flashbacks Nightmares Dissociative Episodes Loss of Time

Recent self-harming behaviors: Yes No If yes, describe: _____ Frequency: _____

Recent suicidal ideation: Yes No Past Attempts: Yes No If yes, when? _____

Method: _____



The Eating Disorders Treatment Center

PRE-ADMIT LAB REQUEST FORM

1525 River Oaks Road West
New Orleans, LA 70123

Patient Name: _____

Dear Doctor and or Laboratory Staff:

Please draw the following pre-admit labs and **FAX** the results to The Eating Disorders Treatment Center at River Oaks Hospital (**Fax: 504-733-3229**).

CBC

CMP

Phosphorus

Magnesium

EKG

Diagnosis to be completed by physician:

Anorexia Nervosa 307.1

Bulimia Nervosa 307.51

Eating Disorder NOS 307.5

FAST FACTS FOR PATIENTS

HOW LONG IS THE AVERAGE STAY?

An estimated length of stay is determined within three days of a patient's admission and amended at times. Determining factors may include insurance authorization and discharge planning.

WHAT ACTIVITIES ARE INCLUDED IN MY HOSPITAL STAY?

- Individualized Treatment Plan
- Medication Management 3x per week
- Individual Therapy 3x per week
- Family Therapy 2x per week
- Daily Group Therapy
- Expressive Therapy
- Discharge Planning - the patient is responsible for his or her own aftercare appointments

TRANSPORTATION

Patients are required to make their own travel arrangements, including transportation from the airport to the hospital. Cab fare from the airport is about \$25 including tip. Patients must speak with an intake counselor to schedule a date and time for admission. We strongly recommend patients purchase an open or one way ticket because lengths of stay are always estimated and discharges must be coordinated with the treating physician.

WHAT CAN I WEAR?

- Comfortable clothes to accommodate for fluctuations in weight
- A light jacket or sweatshirt as unit temperatures tend to be cooler (no drawstrings)
- Bras and undergarments must be worn appropriately
- Clothing should not expose midriffs/shoulders or fit tightly. No short skirts, shorts, or dresses (must be at least knee length)
- Shoes that are slip-on or have Velcro closure

CAN I MAKE CALLS TO FAMILY AND FRIENDS?

There are phones on every unit that patients are permitted to use during scheduled times. Individuals wishing to visit or call must have the patient's ID number and permission to have contact with the patient.

Telephone Times: 6:30-8am & 8:30-10:15pm

Visiting Times: Wed, Sat & Sun 6-8pm

WHAT SHOULD I BRING WITH ME?

- Insurance cards and ID cards
- Names, addresses and phone numbers of current therapists and doctors
- 30 day supply of all current prescription and over the counter medication (no Mediplanners - medications must be in actual bottle)
- Medical information regarding any allergies to medications, foods, or other sources and any information regarding special needs
- Appropriate reading material
- Topical hair remover/battery operated or electric razors
- Blow dryers and hair straighteners, etc., are permitted but must be approved by maintenance staff prior to use

WHAT DO I NEED TO LEAVE AT HOME?

- All electronic devices including, but not limited to, cell phones, laptop computers, tablet/note book computers, MP3 players, TVs, radios, portable gaming devices, and e-cigarettes (Exception: students needing internet access for schoolwork are allowed to bring their laptop, but must bring an AirCard as there is no WiFi)
- Jewelry and other valuables
- Laxatives and diet pills
- Shoe laces, belts, drawstrings (belts on robes)
- Leggings/tights, stockings, tank tops, sports bra style shirts
- Knives, guns or weapons of any kind
- Cigarettes, lighters, candles, illicit drugs, alcohol
- Outside food or beverages
- Glass items (some makeup products can be left in lockers)
- CPAP Machines
- Razors or scissors
- Spiral notebooks
- Towels and hangers