The Eating Disorders Treatment Center
REFERRAL FORM

1525 River Oaks Road West
New Orleans, LA 70123

Riveroaksspecialty@uhsinc.com
Phone: 1-800-366-1740 ext. 126
Fax: 504-733-3229

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.) ____
____
Are you diagnosed with celiac disease? If so, is it currently being treated? ____________________________
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: ____

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PRE-ADMIT LAB REQUEST FORM

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Fax: 504-733-3229

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**

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

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
- 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

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

Questions? Riveroaksspecialty@uhsinc.com

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