Psychiatry Admissions Office
600 N. Wolfe Street, Meyer 143
Baltimore, MD 21287

410-955-5104 Office
410-955-6155 Fax
www.hopkinsmedicine.org/psychiatry

Department of Psychiatry

Treatment Referral Form for Eating Disorders

Date: _____ **Program:** _____

Patient Name: _____ **DOB:** _____

Address: _____

Home Phone: _____ **Cell:** _____ **Other:** _____

Contact Name, Relationship, & Phone Numbers: _____

_____

Referring Clinician's Name, Title, Contact Number, and Email: _____

_____

Insurance Information

Please provide front and back copies of **all** insurance cards or complete the information below.

Primary Insurance Name: _____ **Mental Health Contact #:** _____

Policy/Member ID Number: _____ **Group Number:** _____

Subscriber Name/Date of Birth/Relationship to Patient: _____

Employer: _____

Secondary Insurance Name: _____ **Mental Health Contact #:** _____

Policy/Member ID Number: _____ **Group Number:** _____

Subscriber Name/Date of Birth/Relationship to Patient: _____

Employer: _____

Tertiary Insurance Name: _____ **Mental Health Contact #:** _____

Policy/Member ID Number: _____ **Group Number:** _____

Subscriber Name/Date of Birth/Relationship to Patient: _____

Employer: _____

INITIAL INTAKE ASSESSMENT

DIAGNOSIS:

_____

_____

REASON FOR ADMISSION: (Or attach background and recent history, EKG if appropriate, and recent clinical notes and labs). Include specific eating behaviors for the past six months, recent weight gain/loss. Please check and indicate frequency:

□ Binge Eating _____ □ Vomiting _____ □ Laxatives _____ □ Diet pills _____

□ Recent Weight Loss/Gain in past 6 months: □ Yes □ No If yes, Amount _____

□ Excessive Exercising _____ □ Diuretics _____

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PAST PSYCHIATRIC HISTORY

1. Previous Inpatient, name of program, and year (if known): _____

   _____

   _____

2. Previous Outpatient: _____

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   _____

3. Current Medications (or attach a list): _____

   _____

   _____

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4. History of Suicide Attempts, Homicidal Ideation, History of Aggressive Behavior or Self Injurious Behavior: _____

   _____

   _____

5. History of Substance Abuse or Dependence: _____

   _____

   _____

6. History of Sexual Abuse, Physical Abuse, Sexual Acting Out Behavior:

   _____

   _____

7. Legal History:

   _____

   _____

8. Family History of Psychiatric/Substance Abuse: _____

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MEDICAL PROBLEMS/ALLERGIES:

For Eating Disorder: Height: _____Weight: _____BMI: _____

_____

_____

_____

_____

_____

SPECIALIST/OUTPATIENT TREATMENT TEAM

Specialist	Name	Contact Number	Fax Number
Psychiatrist			
Therapist			
Primary Care Physician			
Other:			
Other:			