Center for Disordered Eating/New Patient Referral (Outside EPIC)

Teen Health Connection Adolescent Medicine	**Phone: 704-381-8336**	**Fax: 704-381-8832**

Dear Health Care Professional: Our initial evaluation includes interviews of patient and parents by a physician/nurse practitioner, registered dietician, licensed therapist, extensive lab work and an EKG. This evaluation usually takes up to two hours. Follow-up visits will initially be weekly, then spaced out accordingly. If you have questions, please call 704-381-8336 and leave a voicemail for the Center for Disordered Eating program. To help us give you the most expedient appointment, please send the following information.

*** This completed form**
*** Growth charts**
*** Summary of why you think this patient has an eating disorder and would benefit from an evaluation.**

Date of Referral:		
Name of Patient:	**Date of Birth:**	**Gender:**
Name of Parent/Guardian:	Relationship:	
Address:		
Phone:		
Insurance Name/Subscriber #:		

Outside Referring MD/RD/therapist:
Practice Name/Address:
Phone: Fax:

Current weight	Date:		Height	Date:
Highest weight	Date:		BMI	Date:
Lowest weight	Date:			

Current Vital Signs (last visit prior to referral)
Temp (<97 consider admission)
HR (<50 consider admission)
BP (Systolic <100 consider admission)
Orthostatic BP/HR (if symptomatic, consider admission)

YES NO		
Amenorrhea?	For how long?	Premenarchal
Food restriction?		
Exercise?	Minutes per day?	
Purging?		
Laxatives/Diuretics/Diet pills?		

Any pertinent family history: _____
Any Medical problems: _____
List other treatment providers (therapist, psychiatrist, nutritionist or another specialist). Include name/phone/discipline). _____

_____
_____

Why you think this patient has an eating disorder and would benefit from an evaluation?

_____
_____
_____
_____