



Referral Form for Nutrition Education Services (Eating Disorder Recovery Program/age 13+)

Tel: (989)400-1478 Fax: (844)364-1295

Thank you for referring your clients to Around the Plate. Please complete this form, then print and fax to (844)364-1295. Please be thorough, as this form will allow us to have all the information necessary to begin providing nutrition education.

Date of Referral:

Demographic Information			
Name of Client:		DOB:	
Address:			
Parent Name:			
Best Contact #:	()	Email:	
Insurance Information			
Insurance Co:			
ID #:		Group #:	
Subscriber Name:		DOB:	
# to Verify Benefits:			
Referral Source			
Referrer Name:		Length of Treatment Relationship:	
Referring Provider NPI #:			
Agency:		Phone:	
Fax:		Email:	
Referring Provider Signature:			
Clinical Information (please attach any pertinent lab values, growth charts, vital measurements, chart notes, and/or medication/supplement lists)			
Primary Diagnosis:			
Comorbid Conditions:			
Ht:	Wt:	BMI:	Recent Weight Changes:
When did ED start:		Food allergies/preferences:	



Clinical Goals	
Primary Goal:	
Secondary Goal:	
ED Behaviors and Frequency	Binge: Purge: Restrict: Exercise: Laxative, diuretic, fat absorber, stimulant use: Other (body checking, weighing, etc):
Previous Mental Health Treatment/Hx	
Substance Abuse Hx:	
Current Medication (name/dose/frequency):	
Do you feel client is medication compliant?:	
Past Medical Hx:	
Any other pertinent social or trauma information?:	
Current Treatment Team Members:	Therapist: _____ PCP: _____ Psychiatrist: _____ Other: _____
Specific Challenges RDN Should Address:	
Comments/Other:	

____ Approve for Outpatient Nutrition Education Services ____ Decline: Reason and Plan:

_____ (staff signature) _____ (date)