The UNC Center of Excellence for Eating Disorders (CEED)
Department of Psychiatry
101 Manning Drive, CB#7160
Chapel Hill, NC 27599-7160
984-974-5217 (p)
984-974-9646 (f)

CEED Outpatient Referral Form

Thank you for your interest in submitting a referral. **At this time, all patients must be referred by a medical provider (preferably a pediatrician or primary care provider).** Our intake team will review your information and respond as soon as possible.

The below is a checklist for a successful referral to CEED's outpatient program.

- Completed CEED referral form
- Labs completed within 2 weeks of the date of referral (see page 5 for a detailed list of labs)
- ECG (as clinically indicated) completed within 2 weeks of the date of referral
- Growth charts (for patients ≤ 19 years)

****Patients will not be scheduled for an evaluation until all of the above have been received.****

Patients currently meeting any of the below criteria MUST be referred for an inpatient review prior to being scheduled for an outpatient evaluation:

- BMI ≤ 17
- Bradycardia < 50 bpm
- Hypoglycemia
- Orthostatic hypotension
- ECG abnormalities
- Lab abnormalities that may require electrolyte repletion
- Weight loss ≥ 15 lbs. in the last 3 months

If your patient meets any of the above criteria or if you are interested in referring a patient for directly inpatient admission, please contact the Inpatient Admissions Coordinator at:
984-974-3834 (p) or 984-974-3779 (f)

Patient Information

Name: _____ **Date of referral:** _____

Date of birth: _____ ***CEED outpatient clinic does not see patients younger than 10 years***

Social security number: _____ **UNC medical record number** (if applicable)**:** _____

Preferred language: _____

Is the patient or patient's parent/guardian a UNC student or employee?: ☐Yes ☐No

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Sex assigned at birth:
☐Female
☐Male
☐Prefer not to say

Gender identity:
☐Woman
☐Man
☐Non-binary
☐Prefer not to say

Pronouns:
☐She/her
☐He/him
☐They/them
☐Other
☐Prefer not to say

Race
☐American Indian or Alaska Native
☐Asian
☐Black or African American
☐Hispanic or Latino
☐Native Hawaiian or Other Pacific Islander
☐White
☐Multi-racial
☐Prefer not to say

Mailing address: _____
Street Address

_____
City, State, Zip, County

Email address: _____

Best phone number: _____ **May we leave a message at this number?** ☐Yes ☐No

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If the patient is a minor, please provide the name, phone number, and date of birth for parent(s)/legal guardian(s).

Name: _____ Relationship: _____ Phone number: _____ Date of birth: _____

Name: _____ Relationship: _____ Phone number: _____ Date of birth: _____

Authorization for the Exchange of Protected Health Information

To be completed by patient or authorized legal guardian/representative

By way of authorizing this referral, I also authorize the UNC Center of Excellence for Eating Disorders (UNC CEED) to communicate with my healthcare provider(s) regarding this referral and any related treatment information. State and federal privacy laws do not require patient authorization for the release of protected health information when the release is for treatment or continued patient care. However, it is the practice of UNC CEED to request patient consent, and, by signing below, I consent to the disclosure of my protected health information for treatment purposes.

State and federal privacy laws require that I consent to the disclosure of my protected health information to family member, except if I am a minor or do not have decision-making capacity. UNC CEED requests my consent to communicate with relevant family members regarding this referral, and by providing names and contact.

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

I understand that this authorization for the exchange of protected health information applies to this referral only and that it will not apply to the release of protected health information related to any treatment that may result from this referral.

I understand that I may revoke this authorization at any time. The revocation will not apply to information that has already been released in response to this authorization. I have been informed and understand that information disclosed to non-healthcare providers pursuant to this Authorization may be redisclosed by the recipient of such information and that, once disclosed, the privacy of the information may no longer be protected under federal privacy laws. Unless otherwise revoked, this Authorization will automatically expire one year from the date of signature.

_____ _____

Signature of patient or legal guardian Date

Insurance Information

Insurance Company Name: _____

Subscriber ID/Policy Number: _____

Group Name: _____

Group #: _____

Insurance Claims Mailing Address: _____

Street Address

_____

City, State, Zip, County

Benefits & Claims Coverage Phone #: _____

Mental Health Coverage Phone #: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Subscriber Address: _____

Street Address

_____

City, State, Zip, County

Effective Date of Coverage: _____

Relationship to Subscriber: ☐Self ☐Spouse ☐Dependent child

Please list any secondary medical insurance coverage if applicable
***For insurance questions, call the Financial Counselor at 984-974-3931*

Referring Provider Information

Provider name: _____ Facility name: _____

Phone: _____ Fax: _____

Referral Information

Weight: _____ **Height:** _____ **BMI:** _____

Eating disorder symptoms:

☐ Binge eating
☐ Restrictive/selective eating
☐ Self-induced vomiting
☐ Compulsive exercise/over exercise
☐ Laxative/diuretic/diet pill abuse
☐ Other

Reason for evaluation: _____

Receipt of the below is required before an evaluation will be scheduled.		
☐ Labs completed in the last 2 weeks • CBC • CMP (including electrolytes, renal function tests, and liver enzymes)	☐ ECG (as clinically indicated) conducted in the last 2 weeks	☐ Growth charts (for patients age ≤ 19 years)

Please send this completed form and requested records to the UNC Center of Excellence for Eating Disorders at the fax number listed below. Thank you!

An evaluation will not be scheduled until all required information is received.

Disclaimer: CEED can conduct an evaluation but cannot guarantee ongoing treatment.

101 Manning Drive, CB#7160
Chapel Hill, NC 27599-7160

984-974-5217
Phone number

984-974-9646
Fax