



Transitional Living Services of Northern New York

REFERRAL TO EATING DISORDERS SERVICES

Date: _____ Referred by: _____
 Title: _____
 Agency: _____
 Telephone#: _____

IDENTIFYING DATA		REFERRED TO:	
Name:		Eating Disorders Services	
Health Insurance:		EMERGENCY CONTACT:	
Health Insurance Number:		Name:	
Soc. Sec. #:		Relationship:	
Date of Birth:		Address:	
Religion:	Identified Cultural Background:		
Marital Status: S M W D Separated		Phone:	
Veteran: Yes	No	Nearest Relative: (if not the same)	
Current Address:		Proxy: Yes	No
Current Telephone #:		Advanced Directives: Yes	No
Usual Symptoms of Recurring Illness/Stressors/Past Problem Areas			
MEDICAL DATA		YES	NO
Most Current Physical Examination			
Mantoux Test (Within 1 yr.) PPD			
Cardiac/COPD Problems			
Diabetes			

Seizure Disorder (Indicate date of last Seizure)			
Allergies			
Limited Ambulation			Able to do stairs?
Any Restrictions of Activities			
NAMES OF OTHER SERVICE PROVIDERS (if applicable)	ADDRESS		
Psychiatrist:			
Medical Doctor:			
Dentist:			
Eye Doctor:			
Primary Therapist:			
Other:			
PSYCHIATRIC DATA:		Agent:	
Diagnosis:	Name	Code	
Axis I:			
Axis II:			
Axis III:			
Axis IV:			
Axis V:			

Current Medications: (Dosage and Frequency) (Psychiatric and Medical)		
Name	Dosage	
		____ Psych ____ Med
		____ Psych ____ Med
		____ Psych ____ Med

FINANCIAL INFORMATION			
FUNDING SOURCE	ELIGIBLE		AMOUNT RECEIVING
	YES	NO	
Social Security:			
Disability:			
Survivors:			
Retirement:			
Disabled Child:			
SSI			
V.A. Pension			
Payee Status	Own Payee ___	Representative Payee ___	Name: Address: Phone: Where?:
Employed			

OTHER COMMENTS

Please have person who is applying for services sign.

I am applying for Eating Disorders Case Management.

Applicant's Signature: _____

Date: _____

Parent/Guardian Signature: _____
(if applicable)

Date: _____

Send referral to

**Eating Disorders Case Manager
North Country Transitional Living Services, Inc.
482 Black River Parkway
Watertown, NY 13601
(315) 782-1777 ext. 34**

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