LA COUNTY DEPARTMENT OF MENTAL HEALTH

REFERRAL FORM: HIGHER LEVEL OF CARE (HLOC) EATING DISORDER TREATMENTS

Any incomplete fields will delay processing.

***Note**: HLOC Eating Disorder Treatment includes Inpatient, Residential, Partial Hospitalization or Intensive Outpatient Levels of Care. This form is only to be used for HLOC.*

SECTION ONE:	
Referring Provider's Name:	
Referring Provider's Clinic Name:	
Referring Provider's Clinic Address, City, State and Zip Code:	
Referring Provider's Phone Number:	
Referring Provider's Email:	

SECTION TWO:	
Client's Name:	
Client's DOB:	
Client's DMH #:	
Client's Address:	
Client's Phone:	
Client's Insurance Plan:	
Client's Medi-Cal #:	
COMPLETE IF CLIENT IS UNDER 18 YEARS OLD	
Client's Caregiver's Name (First and Last Names)	
Client's Caregiver's Phone Number - Primary	
Client's Caregiver's Phone Number - Secondary	

Is Client's Caregiver willing to consent to recommended eating disorder level of care? **Yes** ☐ **No** ☐

Is the Dept of Children & Family Services (DCFS) involved with the minor? If yes, provide DCFS Social Worker's name and telephone number. **Yes** ☐ **No** ☐

***Referral will only be completed if all attachments are included.**

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

SECTION THREE:

How was the client referred to you?

***REQUIRED FOR SUBMISSION**: **Complete the information below:**

Current BMI: **Height:**

Weight: ☐ **lbs** ☐ **kg** **Date Of Weight:**

LABS MUST BE DRAWN WITHIN THE LAST 30 DAYS

***REQUIRED FOR SUBMISSION**

Dates CMP and CBC were completed:

CMP - Date **CBC -** Date

Attach CMP and CBC Panel

Note: If the "Attach CMP and CBC Panel" button does not function, you must manually attach the History & Physical Report to the email submission. The referral will not be reviewed without the attachment.

Any other notes:

CURRENT EATING DISORDER SYMPTOMS/ASSOCIATED BEHAVIORS

1. **Current ED diagnosis/diagnoses and specify any other medical diagnosis**

2. **History (include Onset) of eating disorder symptoms/associated behaviors (ex. restricting, binging/purging frequency, counting calories, exercising, laxative use, diet pill use, highest wt/lowest wt within what time frame).**

3. **How do these symptoms impair the client's daily functioning?**

4. **History of Eating Disorder Treatment (ex. Hospitalizations, other Higher LOC Eating Disorder Treatment, Outpatient):**

*Referral will only be completed if all attachments are included.

5. **If client is a minor, is the family or caregiver open to residential treatment and family therapy?** **Yes** ☐ **No** ☐

HISTORY OF MENTAL HEALTH TREATMENT

1. **Are there current and past diagnosis, and treatment for mental health** **Yes** ☐ **No** ☐

If Yes, please select all that apply and explain below:

☐ **Outpatient Psychiatrist** ☐ **Therapy** ☐ **Psych Hospitalization** ☐ **Current SI/HI/AVH**

☐ **Suicide Attempts** ☐ **Self-injurious hx** ☐ **Substance Use** ☐ **Other:**

Explain the selected diagnosis/treatment:

2. **History of Trauma:**

3. **Is the client currently taking current psychotropic medications and past medication trials?** **Yes** ◯ **No** ◯
If Yes: Please add medication here:

PSYCHOSOCIAL INFORMATION (INCLUDING CURRENT FAMILY DYNAMICS/ SUPPORT/HOUSING, SOCIAL SUPPORTS, SCHOOL/EMPLOYMENT STATUS, WORK HX)

1. **Hx of assaultive behavior**

2. **Hx of involvement with legal system**

3. **Hx of current family dynamics, support/housing**

4. **Hx of school or work status**

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PHYSICAL REPORTS:

1.	**Recent History & Physical Report: Including current medical diagnosis, surgical hx, and medications**	**Select to attach History & Physical Report:** Attach File — Note: If the "attach file" button does not function, you must manually attach the History & Physical Report to the email submission. The referral will not be reviewed without the attachment.
2.	**Recent EKG Report (if available, recommended if purging bx, bradycardia, lightheadedness)**	**Select to attach EKG Report:** Attach File — Note: If the "attach file" button does not function, you must manually attach the EKG Report to the email submission. The referral will not be reviewed without the attachment.

SECTION FOUR: RECOMMENDATIONS

Recommended Level of Care for Eating Disorder Treatment:

☐ **Inpatient, Residential:** acute psychiatric stabilization, medical monitoring, 24-hour nursing care, intensive therapeutic interventions

☐ **Partial Hospitalization:** structured intensive treatment, including 24-hour nursing care and opportunity for "real life" exposure and practice.

☐ **Intensive Outpatient:** focus on practicing daily living skills while continuing to engage in intensive group and individual work.

ADDITIONAL INFORMATION (Utilize the space below to include any relevant information for consideration):

I have reviewed and attached all required documents. I understand that if any of the required documentation or attachments are missing, the referral will not be processed and will be returned as incomplete. The referral will remain in pending status until all required documents are received.

Please note documents can be sent as an attachment via secure e-mail (ed_ect_auths@dmh.lacounty.gov**) if you are unable to upload within this form.

Date:	**Signature:**

To send the form via email, please select the Submit Button or send an email to ed_ect_auths@dmh.lacounty.gov

SUBMIT

CLEAR THE FORM

***Referral will only be completed if all attachments are included.**