Binghamton University Eating Concerns Evaluation Referral Form

Medical providers who have concerns that a Binghamton University student may have disordered eating may refer the student for an evaluation to determine the level of care needed by the student and to assist with referrals to on and off-campus treatment resources. These evaluations do not establish a treatment relationship between our office and the student. You are encouraged to continue to treat your patient until they establish care with us or an off-campus provider. We do not provide emergent services. This is done through our local emergency room, UHS Binghamton General Hospital CPEP, 607-762-2302.

To receive an eating concern evaluation through Binghamton University, current or recent providers must complete and fax this form to our office (607-777-5280). The student will not be given an appointment until this information is received. If we receive notes or records from you that include answers to each of the questions below, the form does not need to be completed.

Once we receive this form we will schedule the student for an evaluation to determine the level of care the student requires. If the student requires more intensive care than what we can provide, they will be assisted in establishing care with an appropriate provider.

1. Student's name: ______________________________

2. Student's birthdate (mm/dd/yyyy): ______________________________

3. Student's diagnoses and brief summary of reasons for referral for eating disorder evaluation. Include statements regarding health concerns or stability; past treatments or programs attended and their effect; medication trials and responses to medications if known. Attach additional paper, if needed:

4. Date of your last appointment with the student: ______________________

5. Date of your next appointment with the student: ______________________

6. Number of sessions/appointment you have had with the student: ______________________

7. Do you plan to continue to treat the student if care is established by Binghamton University? ____________

8. Your recommendations for treatment (e.g. # sessions per week, recommended medical monitoring, group or individual counseling, etc.). OUR COUNSELING CENTER PROVIDES BRIEF THERAPY, some groups and treatment referral coordination. It does not provide long-term therapy).

Therapist/Provider/MD, NP, DO, PA contact information:

Name and credentials: ______________________________

Phone number: ______________________ Fax number: ______________________

Signature: ______________________ Date: ______________________