Eating Disorder Collaboration Request

Client Information

Name: Date of Birth:

Medi-Cal Number:

Address:

Physical health provider (essential):

Behavioral health provider: Y/N Yes

Beacon behavioral health provider: Y/N Yes
If Y, name:

County behavioral health provider: Y/N Yes
If Y, name:

Level of care/placement being sought:

Anticipated length of stay:

Clinician with Principal Responsibility for Eating Disorder Diagnosis/Referral

Name and Licensure of Principal Provider:

Type of Licensure:

Phone/email:

Agency/Clinic:

Contact person (if different):

County Contact Information:

Is referral from a county mental health plan? (Y/N) Yes County:

Fiscal Contact (name, phone, email):

Client Health Information

Current BMI:

Co-occurring conditions (medical, psychiatric, substance use):

Current location of client (i.e., home, facility, foster care, etc.):

Current services to address client's eating disorder:

Summary Information

Please provide details on how the client was first diagnosed with an eating disorder or first came to your attention, and how the proposed level of care was determined including interventions/treatment/provided to date:

Discharge Planning:

Who will be monitoring the client's care during the placement?

Anticipated steps upon discharge?

Consent/responsible party (if not the client):

Please note that collaboration involves communication about the client's progress on at least a monthly basis during the period of collaboration.