Hull House Real Recovery
Accountability • Connection • Love

Provider Referral Form

Thank you for taking time to help us evaluate your client for placement into Hull House Real Recovery. Your answers to all of the following questions are critical to our assessment of your client's appropriateness for our peer support program.

Referral Source Name:

Referral Source Title/ Employer:

Date of Referral:

Client Name:

Please Complete for Clients With History of Addiction/Substance Use Disorder:

Drug(s) of Choice:

- ☐ Alcohol
- ☐ Opiates
- ☐ Stimulants
- ☐ Benzodiazepines
- ☐ Sedative–Hypnotics
- ☐ Anabolic Steroids
- ☐ Cannabis
- ☐ Phencyclidine
- ☐ Hallucinogens
- ☐ Nicotine
- ☐ Inhalants
- ☐ Other: _____

Any IV Opiate Use:

- ☐ Yes
- ☐ No
- ☐ Unknown

How long has your client been drug and alcohol free?

- ⬚ More than one year
- ⬚ Seven months to a year
- ⬚ Four to six months
- ⬚ One to three months
- ⬚ Less than a month

If your client has been drug and alcohol free for less than a month, please provide the number of days: _____

Please tell us your impressions of your client's current denial system.

- ⬚ No Denial
- ⬚ Moderate Denial
- ⬚ High Denial
- ⬚ Extreme Denial

Please Complete for Clients With History of an Eating Disorder:

Eating Disorder Diagnosis:

- ⬚ Anorexia Nervosa
  - ⬚ Unspecified - 307.1 (F50.00)
  - ⬚ Restricting Type - 307.1 (F50.01)
  - ⬚ Binge Eating/Purge - 307.1 (F50.00)
- ⬚ Bulimia Nervosa - 307.51 (F50.2)
- ⬚ Binge Eating Disorder - 307.51 (F50.81)
- ⬚ Other Specified Feeding or Eating Disorder - 307.59 (F50.89)
- ⬚ Avoidant Restrictive Food Intake Disorder (ARFID) - 307.59 (F50.89)
- ⬚Pica
  - ⬚Adults - 307.52 (F50.89)
  - ⬚Children - 307.1 (F98.3)

Other_____

Previous Services/Levels of Care

- ⬚ Evaluation / Program Assessment

- ⬚ Outpatient Therapy
- ⬚ Outpatient Medical Nutrition
- ⬚ Intensive Outpatient Program
- ⬚ Partial Hospitalization Program

Does your client currently use eating disorder behaviors?

- ⬚ Yes
- ⬚ No

Current Eating Disorder Behaviors & Mental Health Concerns

- ⬚ Restricting food intake
- ⬚ Purging thru induced vomiting
- ⬚ Purging thru overexercise
- ⬚ Purging thru laxative abuse
- ⬚ Binge / purge cycles
- ⬚ Binge only behaviors
- ⬚ Extreme weight loss / gain
- ⬚ Restriction of fluid intake
- ⬚ Excessive fluid Intake
- ⬚ Misuse of prescription medications to suppress appetite
- ⬚ Misuse of diet supplements
- ⬚ Excessive caffeine use to restrict
- ⬚ Extremely limited food variety
- ⬚ Avoidance of a certain food groups (carbs, proteins, or fats)
- ⬚ Hiding food to restrict
- ⬚ Hoarding food to binge
- ⬚Resistance to weight gain though medically necessary
- ⬚Chewing / spitting (not swallowing, but tasting)
- ⬚ Anxiety / panic attacks / fear associated with food
- ⬚ Traumatic event associated with food
- ⬚ Social avoidance centered around food related activities
- ⬚ Argumentative / altered personality traits around food
- ⬚ Negative body image / dissatisfaction with self
- ⬚ Distorted view of actual self / body size
- ⬚ Client unable to complete essential daily social, family, school, and/or work activities
- ⬚ Inability to maintain a healthy weight and/or medical stability without the frequency and intensity of structured interventions
- ⬚Client requires a structured program to manage acute eating disorder
- ⬚ Client has a history of suicidal homicial, and/or self harm thoughts

To your knowledge, when was the last time your client used eating disorder behaviors?

Is your client weight-restored?

Is your client currently on a meal plan?

If ‘yes’, please attach a recommended meal plan.

Can your client prepare their own meals?

Can your client consume and complete meals without supervision?

⬚ Yes
⬚ No

If ‘no’, please explain:

Please Complete for All Clients:

Please list any Co-occurring Diagnosis:

Prior Treatment(s):

Recovery Residence History:

Current Medications:

History of Self-Harm:

Recent Suicidal ideation/Homicidal ideation:
⬚ Yes
⬚ No
⬚ Unknown

If yes, how long ago?

Why do you feel that your client has the ability to continue their recovery outside of a community residence?

In what areas has your client made the most progress in treatment?

Please add any additional information that will help us help your client:

Thank you for spending the time to help your client through this referral process. Should your client work with Hull House Real Recovery, we would like to stay in contact with your agency and yourself so that we can all be supportive of this client. Please let us know the best times to contact you and, if possible, a direct phone line.

Referring Source Signature _____

Date _____ Phone number: