UNBOUND
RECOVERY, LLC

Referral Form

Eating Disorder Care

Client Name: _____ **DOB:** _____ **Gender:** M F

Address: _____

Phone: _____

Email Address _____

Reason for referral or diagnosis: _____

ICD-10 Codes:

___ R63.4 Abnormal Weight Loss
___ F50.2 Bulimia Nervosa
___ E66.01 Obesity
___ N91.2 Amenorrhea
___ Z72.4 Inappropriate Diet & Eating Habits
___ F50.01 Anorexia Nervosa
___ E44.0 Moderate Protein Cal Malnutrition
___ F50.8 OSFED
___ R63.5 Abnormal Weight Gain
___ D53.9 Nutritional Anemia

Current Symptoms:

_____

Current medications (including dose and frequency):

_____

Other condition and/or treatment:

_____

_____ _____

Referring Provider Signature **Date**

Contains confidential information protected by state and federal laws. Not to be shared without authorization from Unbound Recovery, LLC.

Referring provider's facility: _____

Referring provider's fax: _____