

Center for Disordered Eating Referral Form

Patient Information

Patients' Name: _____ DOB: _____

Patient's Phone Number: _____

Patient's Address: _____

Guardian's Name: _____

Guardian's Phone Number: _____

Referring Physician

Physician's Name: _____

Practice Name: _____

Address: _____

Phone #: _____

Fax #: _____

Medical Information

Reason for Referral: _____

****Please send with referral any pertinent progress notes, growth charts,
and labs to 704-381-8832.**



Center for Disordered Eating
3541 Randolph Road
Suite 206
Charlotte, NC 28211
Phone: 704-381-HOPE
Fax: 704-381-8832