BH Administrator approval
Stamp will go here

Eating Disorder Bidirectional Form

Please submit the form to the Partnership Behavioral Health (BH) Team at ED_Collab@partnershiphp.org

DATE OF REQUEST:

REQUESTER NAME: **EMAIL:**

URGENT (SAME DAY, END OF BUSINESS) ☐ **PRIORITY** (WITHIN 2 BUSINESS DAYS) ☐ **ROUTINE** (WITHIN 4 BUSINESS DAYS) ☐

Level of care recommendation completed: **Yes** ☐ **No** ☐ (Please contact Partnership BH department for assistance with an assessment, if needed)

Member Information

Name:	Address:	Phone:	
PCP:	**County/Agency:**	**CIN:**	**DOB:**
	Select County		

Services Requested

Inpatient: ☐
Residential: ☐
Partial Hospitalization (PHP): ☐
Intensive Outpatient (IOP): ☐
Care Coordination: ☐
Dietitian: ☐

Do you want Partnership to contract with the provider:
Yes: ☐ No: ☐

** For outpatient services, refer to Carelon with standard referral process

Requested Provider Information

** The provider you would like member to be connected to.

Provider:	Address:	Admission Phone:
Contact Name:	**Phone:**	**Email:**

Referral Submitted: **Yes** ☐ No ☐

Admission Date: (If known) Length of Stay: (If known)

Clinical Information

(Included information should be BMI, height, weight, any medical conditions, co-occuring disorders, diagnosis(es), family or social concerns, homelessness, etc.)

Contact Information

BH Team Coordinator:	Eric Rushing	**Phone:**	(530) 351-9027	**Email:**	erushing@partnershiphp.org
Partnership Care Coordinator Name:		**Phone:**		**Email:**	
County Clinician Name:		**Phone:**		**Email:**	
County Fiscal Name:		**Phone:**		**Email:**	
Primary Care Doctor:		**Phone:**		**Email:**	

Would you like the provider to send clinical updates to your clinician? **Yes** ☐ **No** ☐

Approval Signatures:

Partnership Behavioral Health Representative

County Representative

Revision Date: 4/24/24