To help us obtain authorization and make the best level of care placement for this client, please share your clinical impressions with us. Thank you!

Client Name: Click or tap here to enter text.

Your Name/credentials: Click or tap here to enter text.

Phone: Click or tap here to enter text.

Email: Click or tap here to enter text.

City/State: Click or tap here to enter text.

Clinical Impressions:

- How long you have been treating the client? Click or tap here to enter text.
- Client's current presentation and eating behaviors? Click or tap here to enter text.
- What level of care are you recommending? Click or tap here to enter text.
- Does client have a history of and/or current suicidal ideation or intent? Click or tap here to enter text.
  - If so, could you tell us more about this? Click or tap here to enter text.
  - Also, prior to treatment would they commit to a plan of safety, such as reaching out to you or another provider if they have thoughts of self-harm? Click or tap here to enter text.
- Can you provide information on the family dynamics? Click or tap here to enter text.
- How has the client's eating disorder impacted them socially? Click or tap here to enter text.
- Does the client have a history of extensive alcohol or drug use? Click or tap here to enter text.
  - If so, could you tell us more about this? Click or tap here to enter text.
- Anything else we should know? Click or tap here to enter text.

Additionally, feel free to have the client sign a release for us to speak with you once they arrive in treatment: Release of Information