Intermountain Healthcare
Eating Disorder eConsult Patient Information Form

Purpose and Directions
The Eating Disorder eConsult is a monthly web-based session. Physicians, psychotherapists, and dietitians are available during the session to answer specific questions about eating disorder patients. Healthcare providers can attend and listen or schedule an appointment to talk about a specific patient.

To participate in the Eating Disorders eConsult:
1. Complete this form. Do not provide any identifying information about your patient (name, address, etc.).
2. Click the **Email Form** button at the bottom of this page to open an email with the completed form attached (or email it to linda.webb@imail.org). **If the button doesn't work, save this form and email it to Linda.**
3. The team will email you with a time to call in.

Time: Third Thursday of each month, 12:30 to 1:30 PM, WebEx Meeting ID: 624 968 041#, dial-in: 801-442-6800.

Provider information

Name/credentials: _____ Location (city, state or facility): _____

Phone: _____ Email: _____

Please list any additional treatment team members (name, credentials, and role):

Patient information

Age: _____ Gender: F / M

Marital Status: Single / Married / Divorced / Separated Children in household? Y / N

Patient diagnoses (check all that apply) / duration of illness:

☐ Anorexia Nervosa/_____ ☐ Depression/_____ ☐ Bipolar Disorder/_____
☐ Bulimia Nervosa/_____ ☐ Anxiety/_____ ☐ Personality Disorder/_____
☐ Binge-Eating Disorder/_____ ☐ Insomnia/_____ ☐ Suicidal ideation/_____
☐ Self-harm behaviors/_____ ☐ Other Psych _____

☐ Electrolyte disturbances/_____ ☐ Menstrual dysfunction (oligomenorrhea or amenorrhea)/_____
☐ Malnutrition/_____ ☐ Low bone mineral density for chronological age, osteopenia, osteoporosis/_____
☐ Other medical _____

Prior mental health related hospitalization: Y / N

Prior eating disorder hospitalization: Y / N

Prior residential treatment for eating disorder: Y / N

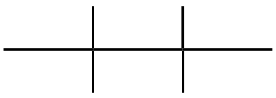
Patient medications:

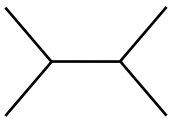
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Wgt (lbs): _____ Hgt (in): _____ BMI: _____ Weight (choose one): loss / gain of _____ lbs

Blood pressure: _____ Pulse: _____ Temp: _____

Labs/Imaging (if available):





AST _____ FSH _____ Estradiol _____
ALT _____ LH _____ Prolactin _____
Albumin _____ TSH _____ Other _____

Dexa scan:

Date _____ Lumbar spine Z-score (age-matched): _____ Femoral neck Z-score: _____

Additional notes (Do not include any identifying information about your patient.)

Note: Save a copy for reference during the eConsult. If this button doesn't work, save to your computer and email to: **linda.webb@imail.org**.

Email Form

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