

Avalon Centers, Inc.

EATING DISORDER TREATMENT CENTER

"A Place to Heal"

REFERRAL FORM

NAME: _____ DOB: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

TELEPHONE: _____

Reason for referral: _____

Primary
Diagnosis: _____

Weight: _____

Height: _____

Current Medications: _____

Medical Concerns: _____

Allergies: _____

Insurance: _____

Referred By: _____

Address: _____

Telephone Number: _____

Fax Number: _____