GOLDEN HOUR
CENTER FOR EATING DISORDERS
Ph; 918-550-2294 Fax: 918-306-8002
goldenhour@sunshinetulsa.org
2235 E 6th St, Tulsa, Ok 74104

Complete all sections **to the best of your ability**.

If certain information is **unknown, unavailable, or not applicable**, please leave those fields blank. Our team will follow up for any additional details if needed.

Patient Demographics

Name: _____

Date of Birth: _____ **Age:** _____

Pronouns: _____ **Gender Identity:** _____

Address: _____

Phone: _____ **Email:** _____

Emergency Contact: _____ **Phone:** _____

Relationship: _____

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Insurance Information

Primary Insurance: _____ Policy #: _____

Group #: _____ Subscriber: _____

Secondary Insurance (if any): _____

☐ Medicaid ☐ BCBS ☐ Other: _____

Copy of card attached: ☐ Yes ☐ No

Referral Source

Referring Provider / Agency: _____

Contact Name: _____ Title: _____

Phone: _____ Fax: _____ Email:

_____

Relationship to patient: ☐ PCP ☐ Therapist ☐ Psychiatrist ☐ Facility

☐ Other _____

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Clinical Information

- **Primary Diagnosis:** _____
- **Secondary Diagnoses:** _____
- **Reason for Referral to IOP:**
  - ☐ Eating disorder symptoms
  - ☐ Malnutrition or weight instability
  - ☐ Transition from inpatient or PHP
  - ☐ Comorbid trauma, anxiety, or mood symptoms
  - ☐ Need for multidisciplinary support (therapy, dietitian, medical)
  - ☐ Other: _____
- **Current Symptoms or Concerns:**

  _____
- **Safety Concerns:** ☐ None ☐ SI ☐ SIB ☐ HI ☐ Other:

  _____
- **Substance Use:** ☐ Yes ☐ No Details: _____
- **Current Medications:** _____
- **Allergies:** _____

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Current Treatment Providers

Type	Name	Organization	Phone	Fax/Email
Therapist				
Psychiatrist / NP				
Dietitian				
PCP / Specialist				

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Requested Level of Care

☐ **Golden Hour IOP (Eating Disorder IOP)** – 3 days/week, ~4 hours/day
Includes group therapy, nutrition therapy, supported snack & lunch, trauma-informed yoga, and medical/psychiatric oversight.
Length: **8 weeks** (or individualized based on clinical need).

Additional services available:

☐ Spravato® (esketamine) evaluation if clinically indicated
☐ Coordination with existing outpatient/inpatient teams

Attachments Requested

☐ Most recent clinical notes (last 30 days)
☐ Medication list
☐ Vitals and labs
☐ Nutrition/weight history
☐ Safety or crisis plan (if applicable)

Referring Provider Signature: _____ **Date:**_____

Printed Name & Credentials: _____