I will engage with the Eating Disorders Support team.

**Counselor:** (740) 593.1616

**INDIVIDUAL THERAPY VISITS**
Frequency of visits

**GROUP THERAPY**
Frequency of visits

**EATING DISORDERS ANONYMOUS MEETINGS**
(EDAATHENSOHIO@GMAIL.COM)
Days and times

**Nutritionist:** Selena Baker (740) 593.0250

**NUTRITIONIST VISITS**
Frequency of visits

I PLAN TO FOLLOW MY MEAL PLAN ____________ PERCENT OF THE TIME.

**Physician:**

**ROUTINE MEDICAL VISITS**
Frequency of visits

**WEIGH-INS**
Days and times

**MEDICATION LIST**
______________________________

**LABORATORY TESTS**
______________________________

**SPECIALIST**
Contact information

**Psychiatrist:**
if recommended
Frequency of visits

**Athletic Trainer:**
Exercise limitations and recommendations

**My safety net:** I will sign records release forms to allow for my physician to communicate about my care plan, weight, concerning or dangerous symptoms and behaviors, and recovery goals with:

- [ ] My parents or support person
- [ ] My eating disorder support team.
- [ ] Outside treatment centers.
- [ ] Coaches or athletic trainers if involved in organized sports.
**My accountability partners:** I will talk about my eating disorder with five or more people.

+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________

**My plans for support and accountability when I am away from campus:**

+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________

**My barriers to recovery:** I will identify my triggers and make plans to remove or minimize them.

+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________

**My motivating factors:** I will focus on the benefits of recovery and being well.

+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________

**I will know when to seek treatment:** When I can no longer engage in my care and exhibit the following behaviors or warning signs, I will seek eating disorder treatment, which may mean leaving school temporarily.

+ Unhealthy weight and vital signs.
+ Physical self-harm.
+ Refusal to follow recommendations from my support team and coaches related to appointments, medication, diagnostic testing, exercise limitations, meal planning, therapeutic activities and weight gain.

**My warning signs:**

+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________
+ __________________________________________

**OhioHealth Campus Care at Ohio University**

_Hudson Hall_
Building 35 on the campus map
_(740) 592.7100_