



Family/Friend Support and Back-up Contract for PHP-ED Patients

Date _____

I _____ understand that my family member/friend

_____ is entering the Partial Hospital Eating Disorder Program at The Center for Balanced Living at 445 E Granville Road in Worthington Ohio beginning _____ and will be in the program for an estimated _____ (days/weeks)*

(*Please note: This is an estimate and may change depending on individual progress and/or needs.)

I understand that due to the severity of her/his eating disorder, increased structure and support is needed.

I recognize that this program is a day treatment only. It does not provide overnight care or direct monitoring of patients outside of the treatment day. The PHP-ED provides 6 hrs of structured care and monitoring for patients Monday through Friday.

In order to assure safety of my loved one, when she/he is not in treatment, I agree to do the following to provide needed back up support. (Check the categories for which you are committed to providing support. Please note: #1 is not optional):

_____ ***** REQUIRED***** Attend the Family Education Group as a part of the therapeutic process in the PHP-ED program while the patient is in treatment. **IT MEETS THURSDAYS AT 5:00 pm**

(If primary family/friend is not available, patient is to identify in advance an alternate family member/friend to attend the family and friends therapy group. Separate Alternate Family and Friends therapy group contract is to be signed by alternate family member/friend.)

_____ If housing is needed for the patient, due to the fact that the patient comes from a distance, I agree to stay in local hotel or alternate housing with the patient to provide support and positive distractions

- _____ Daily monitor the patient for safety when not in treatment.
- _____ Call the patient at dinner or before going to bed to provide additional support and assist in holding patient accountable for following the prescribed meal plan, contracting for safety and treatment compliance. I commit to call ____ (number) nights per week.
- _____ Call the patient in the morning before going to treatment to provide additional support and assist in holding patient accountable for following the prescribed meal plan, contracting for safety and treatment compliance. I commit to call ____ (number) mornings per week.
- _____ Be with the patient when she/he eating a meal that is not included in treatment and stay with the patient for at least one hour after the meal to assure the meal is consumed and not purged.
- _____ Help provide healthy distractions to the distress of managing food intake such as: playing board or card games, watching TV or a video, scrapbooking, etc. and by offering emotional support.

_____ Print name of family member/friend

_____ Signature of family member/friend

_____ Date

_____ Print Name of patient

_____ Signature of Patient

_____ Date

Alternate Family/Friend Support Group Contract for PHP-ED Patients

(If primary family/friend is not available, patient is to identify in advance an alternate family member/friend and the dates they will attend the family and friends therapy group.)

Date _____

I _____ agree to attend the family/friend therapy group in the PHP-ED program each week my loved one is in treatment.

Family and Friends Therapy Group meets THURSDAYS **AT 5:00 pm**

Dates I will attend are: _____; _____; _____; _____

_____; _____; _____; _____

_____; _____; _____; _____

Print Name of Alternate family member/friend

Signature of Alternate family member/friend

Date

F/PHP-ED/Orientation Materials/Family Support and Backup 7.10.2009