



STAT

2545 W. Hillcrest Dr. #205
Thousand Oaks, CA 91320
Admissions: 888.822.8938
FAX: 805.273.5246

Dear Medical Professional, this patient is seeking care to address eating disorder behaviors. For the patient to be placed in one of our eating disorders centers, the following forms, physical assessments, and testing need to be **completed within the 14 days prior to admission.**

CALIFORNIA PROGRAMS ONLY: *Medical clearance signatures must be dated within 5 days of admission (page 5).*

Upon completion, please **fax** all required documentation to the **fax number listed above.**

The following information is **required** to ensure safe and appropriate placement of this patient:

1. **Laboratory testing results** *(must be resulted within the 14 days prior to admission):*
 - CMP
 - PPD skin test (please consult your Admissions Counselor if PPD skin test is not available)
 - Flu Shot (please consult your Admissions Counselor if Flu Shot is not available)
 - COVID-19 PCR Test (Rapid Test Not Accepted, Unless Rapid PCR Test)

2. **EKG Report and Rhythm Strip** *(must be completed within 30 days of admission).*

3. **Updated medication list including all over the counter medications, supplements and medications not prescribed by this office.**

4. **Medical History and Physical Exam** *(forms provided)*

5. **Most recent progress notes** *(if applicable)*

6. **Signed affirmation by the patient's provider stating that the patient is medically stable to participate in treatment (page 5).**

Please call our admissions office with any questions or concerns and thank you for your cooperation and support!

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CURRENT VITAL SIGNS PHYSICAL INFORMATION (ALL REQUIRED):

Sex ____ Gender Identity ____ Height ____ Weight ____ Temperature ____ Respirations ____

Blood Pressure (Sitting) _____ Pulse (Sitting) _____

Blood Pressure (Standing) _____ Pulse (Standing) _____

**Please complete both sitting and standing vitals*

MEDICATIONS – Please include over-the-counter medications, supplements and any known medications prescribed by other providers

(a printed list of medications with letter head or identifying marker from your office is acceptable):

Name	Dose	Route	Frequency	Indication	Other instructions

Allergies: medications/seasonal/contact

Name	Reaction	Name	Reaction

MEDICAL HISTORY

Primary Diagnosis *(check diagnosis which most closely describes the patient’s behaviors):*

- Y **Anorexia Nervosa:** Restriction of intake leading to low body weight, fear of gaining weight/being overweight, distorted view of one’s body. Subtypes: Restricting – restricts intake, Binge/Purge – some episodes of binge eating and/or purging
- Y **Binge Eating Disorder:** Recurring episodes of overeating due to marked feelings of lack of control/ability to stop.
- Y **Avoidant/Restrictive Food Intake Disorder:** Intake is limited based on texture, taste, smell, appearance or past negative experience with food.
- Y **Bulimia Nervosa:** Excessive consumption of food in a short period of time, repeated episodes of purging via self-induced vomiting, laxative abuse etc., concern with body weight and shape.
- Y **Other Specified Feeding/Eating Disorder:** All criteria for Anorexia Nervosa, Bulimia Nervosa and Binge Eating Disorder without significant weight disturbance and with differing frequency of behaviors.

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Other Physical or Mental Health Conditions:

Alcohol Use/Abuse *(if yes, please describe below):*

Illicit Drug/Prescription Drug Abuse *(if yes, please describe below):*

Medical, Psychiatric and Surgical History *(Check all that apply):*

Past Medical/Psychiatric History	When	Stable/Unstable	Resolved	Past Medical/Psychiatric History	When	Stable/Unstable	Resolved
<input type="checkbox"/> Cardiovascular/Heart Disease				<input type="checkbox"/> Kidney Disease			
<input type="checkbox"/> Respiratory Disorders				<input type="checkbox"/> Liver Disease			
<input type="checkbox"/> Blood Disorders				<input type="checkbox"/> Osteoporosis			
<input type="checkbox"/> Cancer				<input type="checkbox"/> Anxiety			
<input type="checkbox"/> Gastrointestinal Conditions				<input type="checkbox"/> Depression			
<input type="checkbox"/> Genitourinary Conditions				<input type="checkbox"/> Psychiatric Hospital Stays			
<input type="checkbox"/> Neurologic Disorders/Events				<input type="checkbox"/> Self-Injurious Behaviors			
<input type="checkbox"/> Head Trauma				<input type="checkbox"/> Homicidal Ideation			
<input type="checkbox"/> Endocrine Disorders				<input type="checkbox"/> Suicide attempts			

Surgical History	When	Description
<input type="checkbox"/> GI Surgeries		
<input type="checkbox"/> GU Surgeries		
<input type="checkbox"/> Cardiovascular Surgeries		
<input type="checkbox"/> Cosmetic Surgeries		
<input type="checkbox"/> Recent Surgeries of any kind		

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Review of Systems (Check all that apply):

Constitutional: <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Pain <input type="checkbox"/> Significant weight change	Eyes: <input type="checkbox"/> Watery/purulent discharge <input type="checkbox"/> Redness <input type="checkbox"/> Blurred/double vision	ENT: <input type="checkbox"/> Hearing loss <input type="checkbox"/> Drainage <input type="checkbox"/> Ringing <input type="checkbox"/> Dizzy <input type="checkbox"/> Pain in ears/sinuses <input type="checkbox"/> Mouthsores <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Dental problems/enamel erosion	Cardiovascular: <input type="checkbox"/> Chest pain <input type="checkbox"/> Edema <input type="checkbox"/> Palpitations <input type="checkbox"/> Hypertension <input type="checkbox"/> SOB with exercise <input type="checkbox"/> Hypotension <input type="checkbox"/> Presyncope/syncopal episodes
Respiratory: <input type="checkbox"/> Cough <input type="checkbox"/> SOB <input type="checkbox"/> Wheezing <input type="checkbox"/> Sputum <input type="checkbox"/> Asthma	Gastrointestinal: <input type="checkbox"/> Appetite loss <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea, Vomiting <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Heartburn	Genitourinary: <input type="checkbox"/> Frequency <input type="checkbox"/> Hematuria <input type="checkbox"/> Dysuria <input type="checkbox"/> Nocturia <input type="checkbox"/> Incontinence <input type="checkbox"/> Impotence <input type="checkbox"/> Amenorrhea <input type="checkbox"/> Irregular menses <input type="checkbox"/> Sexual Dysfunction	Musculoskeletal: <input type="checkbox"/> Joint pain/stiffness/swelling <input type="checkbox"/> Physical weakness <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Arthritis <input type="checkbox"/> Decreased muscle mass
Skin/Breasts: <input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Dry skin <input type="checkbox"/> Lanugo <input type="checkbox"/> Varicose veins <input type="checkbox"/> Breast pain, lumps, discharge	Neurological: <input type="checkbox"/> Headaches <input type="checkbox"/> Lightheaded, dizzy <input type="checkbox"/> Numbness, tingling <input type="checkbox"/> Tremors <input type="checkbox"/> Memory loss <input type="checkbox"/> Confusion	Endocrine: <input type="checkbox"/> Hormone deficiency <input type="checkbox"/> <input type="checkbox"/> Thyroid dysfunction <input type="checkbox"/> <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Heat/cold intolerance <input type="checkbox"/> Excess thirst	Hematological/Lymphatic: <input type="checkbox"/> Bleed or bruise easily <input type="checkbox"/> Anemia <input type="checkbox"/> Enlarged glands
Psychiatric <input type="checkbox"/> Anxiety <input type="checkbox"/> Suicidal ideation <input type="checkbox"/> Depression <input type="checkbox"/> Homicidal ideation <input type="checkbox"/> Insomnia <input type="checkbox"/> Self-harm urges			

Physical Exam:

	Normal	Abnormal	Description (if abnormal)
Skin			
HEENT			
Neck • Thyroid • Lymph Nodes			
Chest			
Lungs			
Heart			
Abdomen			
Genital			
Rectal			
Extremities • Joints • Clubbing/cyanosis • Peripheral pulses			

Additional applicable information not otherwise specified: _____



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Medical Clearance Signatures: *(Please note the signature and date below must be dated within 5 days of admit for clients going to treatment in **CALIFORNIA ONLY**. If the client admits outside of the 5-day window, an updated signature and date will be requested by the admissions counselor)*

Based on the above history and physical examination, this patient is medically stable to enter Alsana's eating disorder treatment.

Provider Signature: _____ **Date:** _____

Must be signed by a Medical Doctor (MD), Nurse Practitioner (NP), or a Physician Assistant (PA-C)

Provider Printed Name: _____

TOTAL ACCESS URGENT CARE STAFF (IF APPLICABLE)

PLEASE NOTE: Istat, LFT and EKG to be completed at TAUC. Please send results with patient.

Feel free to contact Kelly Baynes, Lead Manager of Clinical Operations at TAUC

314.961.2255 (Main Office) || 314.392.7807 (Cell)

Provider Notes (optional):

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