ALSANA

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**. *Medical clearance signatures must be dated within 5 days of admission*. 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)

2. **EKG** *(must be completed within the 14 days prior to 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.**

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)*:

- **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
- **Binge Eating Disorder:** Recurring episodes of overeating due to marked feelings of lack of control/ability to stop.
- **Avoidant/Restrictive Food Intake Disorder:** Intake is limited based on texture, taste, smell, appearance or past negative experience with food.
- **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.
- **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
ϒ Cardiovascular/Heart Disease				ϒ Kidney Disease			
ϒ Respiratory Disorders				ϒ Liver Disease			
ϒ Blood Disorders				ϒ Osteoporosis			
ϒ Cancer				ϒ Anxiety			
ϒ Gastrointestinal Conditions				ϒ Depression			
ϒ Genitourinary Conditions				ϒ Psychiatric Hospital Stays			
ϒ Neurologic Disorders/Events				ϒ Self-Injurious Behaviors			
ϒ Head Trauma				ϒ Homicidal Ideation			
ϒ Endocrine Disorders				ϒ Suicide attempts			

Surgical History	When	Description
ϒ GI Surgeries		
ϒ GU Surgeries		
ϒ Cardiovascular Surgeries		
ϒ Cosmetic Surgeries		
ϒ Recent Surgeries of any kind		

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Review of Systems *(Check all that apply)*:

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

_____

_____

Patient Name_____**Date of Birth**_____

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Medical Clearance Signatures: *(Please note signature and date must be dated within 5 days of admit. If client admits outside of 5-day window, updated signature and date will be requested by admissions counselor)*

Based on the above history and physical examination, this patient is medically stable to enter Alsana's eating disorder treatment within the next 5 days.

Provider Signature:_____ **Date:** _____

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):