



STAT

2555 TOWNSGATE ROAD SUITE 312 WESTLAKE
VILLIAGE, CA 91361
Admissions: 888.822.8938

**WHEN COMPLETE PLEASE FAX INFORMATION TO:
805.273.5246**

Dear Medical Professional, this patient is seeking care to address eating disorder behaviors. **For the patient to be placed in our eating disorder program, the attached form (or office visit note signed by a provider) and medical testing results are required within 14 business days of admission** to ensure safe and appropriate placement of this patient. Please submit the following:

1. Laboratory and testing results

- Basic Metabolic Panel (BMP)
- EKG Report with Rhythm Strip (*completed within 30 days of admission*)
- TB PPD skin test, QuantiFERON Gold or T-Spot (*PPD Skin Test recommended for fastest result*)
- COVID-19 PCR Test
 - *Antigen test accepted if patient provides proof that they have received the full series of the covid vaccine AND booster*
 - *Clients who have been vaccinated still require a negative test*
- Proof of flu shot administration (*if available*)

2. Completed Forms (*attached*) or Office visit note complete with history and physical, height, weight, vital signs, medication list and provider's signature.

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

TOTAL ACCESS URGENT CARE STAFF (IF APPLICABLE)

PLEASE NOTE: STAT, 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)

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An Eating Recovery Community



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CURRENT VITAL SIGNS:

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

Sitting Blood Pressure: _____ Sitting Pulse: _____

Standing Blood Pressure: _____ Standing Pulse: _____

**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
<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"/> Mouth sores <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			
Extremities • Joints • Clubbing/cyanosis • Peripheral pulses			

Based on the completed history and physical examination, this patient is medically stable. *Must be signed by a Medical Doctor (MD), Nurse Practitioner (NP), or a Physician Assistant (PA-C)*

Provider Signature: _____ Date: _____

Provider Printed Name: _____

Patient Name _____ Date of Birth _____ Page 4 of 4