ALSANA®

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)*

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)

Patient Name_____**Date of Birth**_____

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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
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:** 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			
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**