clementine
A MONTE NIDO AFFILIATE *for adolescents*

The patient named below is requesting admission to Clementine for the treatment of an eating disorder.
We have medical professionals who can attend to our clients regularly and on an as needed basis.

Identification

Name: _____

DOB: _____ Age: _____ Sex ____

Orthostatic Vitals

Sitting BP: _____ Sitting HR: _____

Standing BP: _____ Standing HR: _____

Respiratory Rate: _____

Height & Weight

Height: _____

Weight (lbs): _____

Date & Time of Above Weight: _____

Growth Chart (*Please Attach)

Current Risk Assessment

Suicidal Ideation	☐ Yes	☐ No
Suicide Attempt(s)	☐ Yes	☐ No
Homicide Ideation	☐ Yes	☐ No
Substance Abuse	☐ Yes	☐ No
Self-Harm Behaviors	☐ Yes	☐ No

Ambulatory Status

☐ Yes, ambulatory

☐ No

Current Eating Disorder Behaviors
Include Frequency & Amount

☐ Bingeing _____

☐ Self-Induced Vomiting _____

☐ Laxatives _____

☐ Exercise _____

☐ Calorie Restriction _____

☐ Other (dieuretics, deit pills, etc.) _____

_____

_____

Allergies & Reaction

Food: _____

Drug: _____

Laboratory / Diagnostics (Required)

☑ **Comprehensive Metabolic Panel** (CMP)
(include Phosphorous & Magnesium)

☑ **Complete Blood Count (CBC)**
Include Thyroid, FSH, LH, & Estradiol

☑ **HCG (Pregnancy Test)**

☑ **Amylase**

☑ **Urine Drug Screen and Alcohol Screening**
include Opiates, Benzodiazepines, ETOH, Amphetamines, Marijuana & Narcotics

☑ **EKG**

☑ **Record of Immunization**

Communicable Disease

Does your patient have Tuberculosis (TB)? ☐Yes ☐No

** Please attach the results of PPD**

Any other communicable illness? _____

_____

_____

Provisional Diagnosis

☐ Anorexia Nervosa

☐ Anorexia Purge Type

☐ Bulimia Nervosa

☐ Binge Eating Disorder

☐ Other Specified Feeding / Eating Disorder

Any Medical Issues, or Special Diet Requirements that may impact or influence our care of your patient? (Celiac, IBS, injuries, etc)

_____

_____

_____

_____

Forms can be faxed to:

Currently Prescribed Medications

Please indicate [✔) which medication(s) **ARE PRESCRIBED** by the **Physician COMPLETING this Medical Clearance**.

Psychotropic Medications	Dosage	Frequency	Indication	✔
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐
OTHER Pertinent Medications	**Dosage**	**Frequency**	**Indication**	✔
				☐
				☐
				☐
				☐
				☐
				☐
				☐

Physician's Statements
(Required For Admission)

Based on my evaluation, this client is medically appropriate to receive treatment in a Residential setting and is able to self-administer medications.

PHYSICIAN'S SIGNATURE DATE

PHYSICIAN'S NAME

ADDRESS

PHONE FAX E-MAIL

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