Clementine

Medical Clearance

Please return to: _____

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

Patient Identification

Name: _____

DOB: _____ Age: _____

Sex: _____

Orthostatic Vitals

Sitting BP: _____ Sitting HR: _____

Standing BP: _____ Standing HR: _____

Respiratory Rate: _____

Height & Weight

Height *(ft. & in)*: _____

Weight *(lbs.)*: _____

Date & Time of Above Weight: _____

Diagnosis

☐ Anorexia Nervosa, Restricting Type

☐ Anorexia Nervosa Binge-Eating / Purging Type

☐ Bulimia Nervosa

☐ Binge Eating Disorder

☐ Other Specified Feeding / Eating Disorder
(e.g. Atypical Anorexia Nervosa, etc.)

Admission Activity Level

Please indicate the level of activity this client may participate in:

☐ None

☐ Light*(nurse observed exercise - RTC only)*

☐ *Full (light yoga and 15 min. walks)*

Current Eating Disorder Behaviors
Include Frequency & Amount

☐ Bingeing _____

☐ Self-induced vomiting _____

☐ Laxatives _____

☐ Exercise _____

☐ Calorie restriction _____

☐ Other _____

Allergies

Food: _____

Drug: _____

Celiac? ☐ Yes ☐ No *(If yes, attach biopsy results)*

STAT: Laboratory / Diagnostics (Required)

☐ **Comprehensive Metabolic Panel *(CMP)***

☐ **Complete Blood Count *(CBC)***

☐ **Phosphorous**

☐ **Magnesium**

☐ **HCG *(Pregnancy Test)***

☐ **Amylase**

☐ **Urine Drug Screen and Alcohol Screening**

☐ **Quantiferon Gold or TB/PPD Form**

☐ **EKG**

Communicable Disease

Does this client have Tuberculosis *(TB)*? ☐Yes ☐No

(results must be given within 3 months of admission - see attached Quantiferon Gold or TB/PPD Form)

Does client have any other communicable diseases?
☐Yes ☐No

Current Risk Assessment

☐ Suicide Ideation ☐ Yes ☐ No

☐ Suicide Attempt(s) ☐ Yes ☐ No

☐ Homicide Ideation ☐ Yes ☐ No

☐ Homicide Attempt(s) ☐ Yes ☐ No

☐ Self-Harm Behaviors ☐ Yes ☐ No

Any Medical Issues / Diet Requirements that may impact / influence care of client?

_____

_____

_____

_____

Currently Prescribed Medications

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

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

Is this client able to be compliant with medication(s) in an unstructured outpatient setting? ☐ Yes ☐ No

Physician's Statement
*(**Required For Admission**)*

I declare this client medically stable to receive treatment for an eating disorder at the below treatment setting:

☐ **Residential** ☐ **Day Treatment (PHP) / Intensive Outpatient (IOP)**

This client is able to self-administer medication(s)? ☐**Yes** ☐ **No**

Physician's Name & Credentials, Address and Telephone Number ***(stamp acceptable)*****:**

Physician Signature: _____ **Date:** _____

Clementine

TB/PPD Test Form

Please return to: _____

The client named below is requesting admission to Monte Nido & Affiliates for the treatment of an eating disorder. We have medical professionals who can attend to our clients on an as needed basis.

Patient Identification

Name: _____

DOB: _____ **Age:** _____

Sex: _____

TB/PPD Test

Name of Manufacturer: _____

Lot #: _____ **Expiration Date:** _____

Dose of Tuberculin Used: _____

Mantoux Test Placed: _____ ☐ **Left Arm** ☐ **Right Arm**

Test Placed by: _____

Date of TB Test: _____

Test Read *(48 - 72 hours later)*

Reading Mm Duration: _____

Reading Description: _____

Test Read By: _____

TB Results *(Required)*

☐ **Positive** ☐ **Negative**

Chest X-Ray *(if applicable, attach report)*

Chest X-Ray Date: _____

Results: ☐ **Positive** ☐ **Negative**