MEDICAL CLEARANCE FORM

The client named below is requesting admission to Peaceful Meadows Recovery Center for treatment of an eating disorder.

Please return form to: Curtis Martin

Fax: 315-759-6029

Patient identification:

Name: _____

DOB: _____

Sex: _____ Age: _____

Address: _____

_____

Phone Number: _____

Orthostatic vitals

Sitting BP: _____ Sitting HR: _____

Standing BP: _____ Standing HR: _____

Respiratory rate: _____

STAT; Laboratory/Diagnostics

REQUIRED

( ) Comprehensive Metabolic Panel

( ) Complete Blood Count

( ) Phosphorous

( ) Magnesium

( ) Potassium

( ) Amylase

( ) HCG (pregnancy test)

( ) Rubeola and Rubella Titers

( ) TSH

Height and Weight:

Height: (ft/in) _____

Weight (lbs) _____

Allergies

Food: _____

Drug: _____

Celiac ( ) yes ( ) no

If yes, attach results

Current ED Behaviors

( ) Bingeing ( ) Laxatives

( ) Exercise ( ) Calorie Restriction

( ) Self Induced Vomiting

Is this client able to self-administer meds? ( ) yes ( ) no

Please attach a list of all meds or natural supplements

Physician's name: _____

Address: _____

Phone: _____

Fax: _____

Physician's Signature:

_____