EDCare
www.eatingdisorder.care

8300 College Boulevard, Suite 300
Overland Park, KS 66210
Main: (913) 9451277
Fax: (913) 553-2547

PHP/EIOP MEDICAL CLEARANCE FORM

Name: ______________________________ Date of Birth: ______________

Known Diagnoses: ______________________________

Allergies to Medications: ______________________________

Allergies to Foods (Note: because an eating disorder may include the volitional restriction of certain foods, declared food allergies must include the results of skin testing or positive history of severe histamine reaction). Diagnosis of gluten intolerance must include antigen testing or biopsy results: ______________________________

Current Medications and Dosage - If diabetic, please include specific insulin types, dosages, and method of administration.

The following information and tests are necessary and must be included in medical clearance. Patients will not be considered to be cleared and scheduled for admission until all data has been received and reviewed.

A. Date of exam: **Physical Exam**

Ht:	Wt: Wt. Change:	Sitting Blood Pressure-Heart rate:	Temperature:
Orthostatic Blood Pressure and Heart Rate: Supine:		**Standing:**	

Significant findings at this time:

____

B: EKG (include ECHO if abnormal EKG) **Please attach full EKG results.**

C: LABS: ALL of the following labs must be completed:

○ Comprehensive Metabolic Panel	○ Serum Phosphate	○ CBC
○ Thyroid Function Test (T3 and TSH)	○ Serum Magnesium	○ Urinalysis
○ HgA1C (if diabetic) from within last 3 months	○ Pregnancy Test (if female)	○ Urine Toxicology

D: FLU SHOTE: EDCare strongly encourages patients to get flu shots before admission.

Please indicate any abnormal test results, and the plan to address these at this time:

____

Are there any ongoing medical concerns or labs that should be followed in an outpatient capacity?

____

Does the patient have any mobility limitations or present a fall risk?______________________________

Is the patient able to transport himself/herself to and from a day program safely? ______________________________

After interviewing the patient, reviewing available medical records, lab values and physical exam, I find ______________ medically stable and able to participate in an eating disorder day program.

Provider's Phone Number: ______________________________

Provider's Printed Name: ______________________________

Provider's Signature: ______________________________Date: ______________

Please fax completed form and results to: (913) 553-2547

Dear Provider,

In preparation for your patient's admission to our eating disorder program, please order the following lab work and complete the enclosed form. This is needed by our team to assess the medical stability of your patient. Upon discharge, we will send you a summary of your patients care during their time here.

Respectfully,

Darcy Scheeler, MD

Darcy Scheeler, MD
Medical Director
EDCare

Please contact your local admissions department if you have any questions.

Denver (303) 771-0861

Colorado Springs (719) 578-5132

Kansas City (913) 945-1277

Omaha (402) 408-0294