EDCare
www.eatingdisorder.care

MEDICAL CLEARANCE FORM
Denver Fax: (720) 889-4258
Kansas City Fax: (913) 553-2547
Omaha Fax: (620) 820-7643

Name: _____ Date of Birth: _____

Known Diagnoses: _____

Allergies to Medications: _____

Allergies to Foods *(Note: 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 result.
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 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: Growth Chart: For individuals ages 18-25, if available.
D: LABS: ALL of the following labs must be completed:

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

E: FLU SHOT: EDCare strongly encourages patients to get flu shots before admission.
F: FOR ADOLESCENTS (ages 17 and under), please provide:

- o Growth chart to date
- o Complete record of immunization history

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 themselves 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 Printed Name: _____ Provider's Phone #: _____

Provider's Signature: _____ Date: _____

Please fax completed form and results to desired EDCare location. Numbers are listed at the top of this document.

FOR INTERNAL USE ONLY

After reviewing all medical information, I have determined the patient:

☐ Is medically cleared to admit to EDCare. ☐ Is NOT medically cleared to admit to EDCare

Reviewed by: _____ **Date:** _____

Additional Comments: _____

_____

Dear Provider,

In preparation for your patient's admission to our eating disorder treatment program, please order the following lab work and complete the enclosed form. EDCare uses this information to assess your patient's medical stability and confirm they are medically appropriate for their clinically determined level of care, helping us provide safe and effective eating disorder treatment.

Review of medical clearance information does not establish a patient-provider relationship with EDCare medical staff. If a medical concern is identified during the medical clearance process, it remains the responsibility of the ordering provider and/or the patient to address it.

Upon discharge, we will send you a summary of your patient's care during their time at EDCare.

Respectfully,

Danielle Burton, MD

Danielle Burton, MD
Medical Director
EDCare

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

Denver (303) 771-0861

Kansas City (913) 945-1277

Omaha (402) 408-0294