



McCallum Place Eating Disorder Treatment Programs

Our programs and multiple levels of care provide comprehensive eating disorder treatment and support.

Please complete this form so that we can complete our preadmission screening. Thank you.

Name Date of Birth

Exam: _____
_____/_____/_____

Date General

Height Weight Temp

Pulse: Standing Sitting Blood Pressure: Standing Sitting

Skin Heent

Cardiac Lungs

Abdomen Extremities

Neuro GU Date of last PAP, if indicated.

Does patient have any complaints of physical pain? If yes describe _____

Summary: _____

Preadmission Checklist please fax dated copy

- EKG
- ELECTROLYTES/BUN/MAGNESIUM/PHOSPHORUS
- LIVER PANEL, AMYLASE, CHOLESTEROL, ALBUMEN AND TOTAL PROTEIN
- CBC
- HEPATITIS SCREEN
- URINALYSIS
- PREGNANCY TEST

Please Place TB test results	/ /
	Date

/ /

Hepatitis A : Date of Vaccination please vaccinate against Hepatitis A so your patient may participate in our cooking.

List of Medical Problems:

List of current Medications:

Statement that your patient is free from communicative diseases:

Signature

Office Phone	Fax
--------------	-----

medical INFORMATION