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