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:____

____

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____

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.

Food Allergies: ____
____

Type of allergy testing used to confirm: ____

In order to support you with the best care, we require that any reported food allergies be accompanied by validated testing (oral challenge, skin prick, serum IgE antibodies, biopsy) by a physician. **We cannot accommodate food allergies without proper testing, so please provide appropriate documentation.**

List of Medical Problems:

____
____

List of current Medications:

____
____
____
____

Statement that your patient is free from communicative diseases:

____

____
Signature

____
Office Phone Fax