McCallum Place
Eating Disorder Centers

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.

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