Monte Nido & Affiliates
Treating Eating Disorders

Monte Nido,
Clementine,
& Oliver-Pyatt Centers

Medical Clearance

Please return to: Monte Nido Admissions Fax: 305-424-7448

The client named below is requesting admission to a Monte Nido & Affiliates program for the treatment of an eating disorder. We have medical professionals who can attend to our clients on an as needed basis.

Patient Identification

Name: ____________________

DOB: ____________ Age: ________

Sex: ________

Orthostatic Vitals

Sitting BP: ________ Sitting HR: ________

Standing BP: ________ Standing HR: ________

Height & Weight

Height *(ft. & in)*: ____________________

Weight *(lbs.)*: ____________________

Date & Time of Above Weight: ____________

Diagnosis

- ☐ Anorexia Nervosa, Restricting Type
- ☐ Anorexia Nervosa Binge-Eating / Purging Type
- ☐ Bulimia Nervosa
- ☐ Binge Eating Disorder
- ☐ Other Specified Feeding / Eating Disorder
  (e.g. Atypical Anorexia Nervosa, etc.)

Admission Activity Level

Please indicate the level of activity this client may participate in:

- ☐ None
- ☐ Light *(nurse observed exercise - RTC only)*
- ☐ *Full (light yoga and 15 min. walks)*

Current Eating Disorder Behaviors Include Frequency & Amount

- ☐ Bingeing ____________
- ☐ Self-induced vomiting ____________
- ☐ Laxatives ____________
- ☐ Exercise ____________
- ☐ Calorie restriction ____________
- ☐ Other ____________

Allergies

Food: ____________________

Drug: ____________________

Celiac? ☐ Yes ☐ No *(If yes, attach biopsy results)*

STAT: Laboratory / Diagnostics (Required)

- ☐ **Comprehensive Metabolic Panel *(CMP)***
- ☐ **Complete Blood Count *(CBC)***
- ☐ **Phosphorous**
- ☐ **Magnesium**
- ☐ **HCG *(Pregnancy Test)***
- ☐ **Amylase**
- ☐ **Urine Drug Screen and Alcohol Screening**
- ☐ **Quantiferon Gold or TB/PPD Form**
- ☐ **Rubeola and Rubella Titers**
- ☐ **Growth Charts**
- ☐ **EKG**

Communicable Disease

Does this client have Tuberculosis *(TB)* ? ☐Yes ☐No
(results must be given within 3 months of admission)

In the past year, has this client lived or traveled outside the USA?
Yes ☐ No ☐

If yes, when and where? ____________

Does client have any other communicable diseases? ☐ Yes ☐ No

Current Risk Assessment

Suicide Ideation ☐ Yes ☐ No

Suicide Attempt(s) ☐ Yes ☐ No

Homicidal Ideation ☐ Yes ☐ No

Homicide Attempt(s) ☐ Yes ☐ No

Self-Harm Behaviors ☐ Yes ☐ No

Any Medical Issues / Diet Requirements that may impact / influence care of client?

____

____

____

Currently Prescribed Medications

Please indicate [✔] which medication(s) **ARE PRESCRIBED** by the **Physician COMPLETING Medical Clearance**.

Psychotropic Medications	Dosage	Frequency	Indication	✔
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐
OTHER Pertinent Medications	**Dosage**	**Frequency**	**Indication**	✔
				☐
				☐
				☐
				☐
				☐
				☐
				☐

Is this client able to be compliant with medication(s) in an unstructured outpatient setting? ☐ Yes ☐ No

Physician's Statement
(Required For Admission)

I declare this client medically stable to receive treatment for an eating disorder at the below treatment setting:

☐ **Residential** ☐ **Day Treatment (PHP) / Intensive Outpatient (IOP)**

This client is able to self-administer medication(s)? ☐ **Yes** ☐ **No**

Physician's Name & Credentials, Address and Telephone Number *(stamp acceptable)*:

Physician Signature: ______________________________ **Date:** ________________

Monte Nido & Affiliates
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TB/PPD Test Form

Please return to: Monte Nido Admissions Fax: 305-424-7448

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Patient Identification

Name: ______________________

DOB: ______________________ **Age:** __________

Sex: ______

TB/PPD Test

Name of Manufacturer: ______________________

Lot #: ______________ **Expiration Date:** __________

Dose of Tuberculin Used: ______________________

Mantoux Test Placed: ______________________ ☐ **Left Arm** ☐ **Right Arm**

Test Placed by: ______________________

Date of TB Test: ______________________

Test Read *(48 - 72 hours later)*

Reading Mm Duration: ______________________

Reading Description: ______________________

Test Read By: ______________________

TB Results *(Required)*

☐ **Positive** ☐ **Negative**

Chest X-Ray *(if applicable, attach report)*

Chest X-Ray Date: ______________________

Results: ☐ **Positive** ☐ **Negative**