



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 / ____ / ____

Date General

Height Weight Temp

Sitting: Blood Pressure / Pulse **Standing:** Blood Pressure / Pulse

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
- Comprehensive Metabolic Panel
- Magnesium
- Phosphorus
- CBC
- Hepatitis Screen
- Urinalysis
- Pregnancy Test
- Growth Charts (*adolescent patients only*)

_____/_____/_____
Please Place TB test results **Date**

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

_____/_____/_____
 Influenza Vaccine : Date of Vaccination and where the vaccine was received

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:

Allergies to medications:

Statement that your patient is free from communicable diseases:

Signature _____

Office Phone _____ Fax _____