MARIN VISTA
HEALTH & WELLNESS CENTER

Medical Clearance Form

Dear Primary Care Provider:

Your patient _____is seeking admission into Marin Vista Health & Wellness Center. Prior to entry into treatment, the patient must provide clinical determination of medical stability. We require that all patients have a **complete physical examination with neurological exam** and **laboratory evaluation within 10 days prior to admission.** Please fax Marin Vista Health & Wellness Center (**f.866.356.7299**, ph.415.331.1302) a copy of your lab work and a statement from you that you believe the patient is medically stable for outpatient eating disorder treatment. Please also indicate your next appointment date and how often s/he should be seen by you.

Date of Exam: _____

Next Appointment Date *(*Please note: Patients in our Partial Hospitalization Program MUST be seen weekly*)***:**

_____

Recommended Frequency of Office Visits:_____

Abnormal Medical Findings or Concerns:

_____
_____
_____

Medications:

_____
_____

Allergies:_____

Height:_____
Weight:_____
Temperature:_____
Respiration Rate:_____

Blood Pressure/Heart Rate (supine): _____
Blood Pressure/Heart Rate (standing): _____
Symptoms of orthostasis (if any): _____

DXA Results (if available): _____
Date of DXA (if available): _____

Do you have toxicology results? Y N *If yes, please include a copy with this form.*

Are your patient's immunizations up to date? Y N *If yes, please include a copy with this form.*
If no, please provide proof of waiver or plan to vaccinate patient.

Does your patient need assistance with any of the following?

- Speech: Y N *If yes, please provide details on the type of assistance needed.*
- Language: Y N *If yes, please provide details on the type of assistance needed.*
- Hearing: Y N *If yes, please provide details on the type of assistance needed.*

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Does your patient present with or have a history of the following *(if so, please elaborate below):*

Electrolyte Imbalance	Y	N	Hx	Cardiac Irregularities	Y	N	Hx
Syncope	Y	N	Hx	Dizziness	Y	N	Hx
Dehydration	Y	N	Hx	Edema in extremities	Y	N	Hx
Esophageal tearing	Y	N	Hx	Blood in emesis or stool	Y	N	Hx
Extreme weakness/fatigue	Y	N	Hx	Osteoporosis/Osteopenia	Y	N	Hx

_____

_____

Please include a copy of the following lab results and EKG both administered within the past 10 days and explanations for any abnormalities:

- Comprehensive Metabolic Panel (Including Magnesium and Phosphorus)
- Lipid Profile
- Complete Blood Count
- EKG
- Urine Analysis
- ESR
- Prealbumin
- TSH
- LFT

Below is a reference of commonly used criteria for medical stability.

Clinical Determination of Medical Stability

1) Weight stable and/or gaining
2) Minimum weight 75% of IBW
3) Min resting HR >45 beats/minute
4) Absence of cardiac arrhythmia
5) Minimal orthostatic pulse and blood pressure change (increase of HR less than 35 with standing from supine position and less than 10 point drop in systolic blood pressure with standing from supine position)
6) Body temperature >96.6 degrees
7) Electrolytes within normal range
8) Absence of seizures or syncope (fainting)

Indications for Medical Hospitalization

1) Severe disabling symptoms that have not responded to PHP
2) Dehydration
3) Severe malnutrition (less than 75% of IBW or rapid precipitous weight loss)
4) Severe electrolyte abnormalities (i.e. serum sodium less than 123; potassium less than 2.5; bicarbonate greater than 36mgEq/L
5) Bradycardia (HR less than 45 beats per minute)
6) Cardiac arrhythmias or ECG changes; prolonged QT interval greater than .44; T-wave depression or U-waves
7) Orthostasis (drop in systolic BP greater than 10 with standing; increase in HR greater than 35 with standing)
8) Hypothermia (body temperature 96.6 degrees or less
9) Other medical complications of malnutrition (i.e. syncope, seizures, etc.)

_____

Provider Name and Credential **Provider Signature**

_____

Date of Exam **Office Phone Number**