

Dear Physician:

La Luna Center provides an Intensive Outpatient Program for the treatment of eating disorders. The program is designed for patients who suffer from serious problems with anorexia, bulimia, or compulsive overeating, but who are not medically compromised and in need of a more restrictive inpatient level of care.

_____ has applied for admission to the program and has listed you as her primary care physician. We hope that, as her primary care physician, you are willing to provide us with necessary information regarding her medical history and current status. We need to assess the patient's medical stability and capacity for participating in an intensive, nine hour-per-week treatment program. The results of your examination, along with all tests and lab findings, will be reviewed by our medical consultant and treatment team and is considered an essential part of our admissions procedure.

Enclosed is the clinical data form. Should you have any questions or need any further information, please call us at 720-470-0010. At La Luna Center we consider the primary care physician a valued member of the treatment team and welcome your input into patient care. Thank you in advance for your cooperation.

Sincerely,

La Luna Center Treatment Team

**La Luna Center Admission Requirements
Physician's Report for Medical Clearance**

Patient must meet the following criteria:

- 1) be declared medically stable by a physician to receive treatment in the outpatient program
- 2) PPD clearance
- 3) be able to self-administer medication
- 4) be able to manage pre-existing medical conditions
- 5) be free from any infectious or contagious diseases

Patient Name _____ DOB ____ / ____ / ____ M/F _____

PPD test date and results _____

Please attach copies of the following tests or have them forwarded to the enclosed address:

1. EKG
2. Chemistries (Chem 20)
3. UA
4. Pregnancy Test CBC with diff
5. Nuclear Medicine Bone Density

For adolescent patient, please include a copy of the growth curve.

History and Physical

Allergies (Drug or Food) _____

Medications (Rx, OTC, herbs and supplements) _____

Past Medical History -the following diagnoses are of particular importance in the management of eating disorders.

- diabetes
- inflammatory bowel disease
- Chrons disease
- Cystic fibrosis
- Liver Disease
- Gallbladder Disease

Hospitalizations/Surgeries : (please list)

Review of Symptoms (circle common problems, add pertinent

positives)

- hair Loss
- heartburn/indigestion
- bloating
- hemetemesis
- abdominal pain and tenderness
- depression/suicidal ideation
- anxiety
- fainting/dizziness
- palpitations
- complications with pregnancy
- infertility problems
- illicit drug use

Physical Exam

Weight Today _____ Height _____

Previous weights over past year:

Date _____ Weight _____

Date _____ Weight _____

Date _____ Weight _____

LMP _____

If no menstruation, weight at time of loss _____

T _____ R _____ BP(sitting) BP(standing)
P (sitting) P (standing)

Please Circle **N**= Normal **A**= Abnormal, and describe abnormal:

General N/A _____

HEENT N/A (parotid swelling, ketotic breath) _____

Hair N/A _____

Neck N/A _____

Chest N/A _____

Heart N/A _____

Lungs N/A _____

Abdomen N/A _____

Skin N/A (lanugo, yellow palms and soles, jaundice, callus on fingers)

Lymph N/A _____
Musculo/Skel N/A _____
Neuro N/A (point tenderness at points of impact for exercise –occult fractures)

Breast N/A _____
GU N/A (within past year) _____
Mentation N/A _____

Assessment

1. General Physical Health (especially cardiac status)
2. Medical Diagnoses
3. Contagious or Infectious Disease yes / no

Plan

1. Medications (include dosage)
Able to manage own medications yes / no
2. Exercise Limitations
 Full light exercise no exercise other physical limitations
3. Other recommendations, follow-up, or referral

I certify that the patient above is medically stable for ongoing intensive outpatient care.

Name of Physician

Address

Signature

Date

Phone/Fax

Thank you for your cooperation.