

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: (Boulder 720-470-0010 or Fort Collins 970-282-8282). **This report can be faxed to 303-200-7098 for both Boulder and Fort Collins patients.**

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

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
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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
hemetemesi
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)
