LA LUNA CENTER

Dear Medical Professional,

This patient is seeking care to address **disordered eating behaviors**. The following forms, physical assessments and testing are required to be completed and returned within 7 days of this appointment. **Fax to 303-200-7098. Questions? Call us at 720-470-0010**

Client Name: _____Date of exam: _____ Date of birth: _____

Current medications and dosage: _____

_____

Physical health conditions: _____

Known diagnosis: _____ Alcohol/drug abuse: _____

Allergies: _____

The following vitals are all required.

Sex		**Gender Identity**	
Height		**Weight**	
Last 30 day weight change		**BMI**	
Blood Pressure (sitting)		**Pulse (sitting)**	
Blood Pressure (standing)		**Pulse (standing)**	
Date of last DEXA		**Temperature**	

These 9 recent labs & tests (within the last 30 days) are all required (check to mark each box as completed and attached).

☐ **CMP** (Comprehensive Metabolic Panel)	☐ **CBC** (Complete Blood Count) **with differential**
☐ **Phosphorus**	☐ **EKG** (please attach full EKG results)
☐ **Magnesium**	☐ **Pregnancy test**
☐ **Vitamin D**	☐ **Thyroid Function Test – T3 and TSH**
☐ **Urine Toxicology Report**	

Abnormal lab test results: _____

_____

Significant findings: _____

_____

EKG is: Normal | Abnormal (please circle one)

LA LUNA CENTER

Medical Professional Attestation

Based on my physical examination, review of lab test results, and review of available medical records I certify that this patient is medically stable, able to administer their own medication, and appropriate to attend the recommended treatment program as determined by La Luna Center.	
Provider Signature:	
Printed Provider Name:	
Date:	
Phone Number:	
Email:	
Fax Number:	

Follow Ups & Recommendations:

Follow - Up Office Visit:
Follow - Up Lab Work:
Exercise / Movement Restrictions (Please Check One): □ I defer to the recommendations of La Luna Center's eating disorder treatment team. □ Other:
Other:

If EKG is abnormal:

I have reviewed the abnormal EKG for this patient and am not recommending follow-up care at this time. I understand that this patient will be entering an ambulatory facility within the next 28 days and confirm that the patient is medically stable and appropriate for these settings.	
Provider Signature:	
Printed Provider Name:	
Date:	