The Journey Therapy
Kailua, Hawaii

Intensive Outpatient Program
328 Uluniu St. #202
Kailua, HI 96734
Fax: (866) 278-4162

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 prescribed/ over the counter 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:

EKG
Chemistries (Chem 20)
UA
Pregnancy Test
CBC with diff
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: Please circle all that apply.

Diabetes
Inflammatory Bowel Disease
Chrons Disease
Cystic Fibrosis
Liver Disease
Gall Bladder Disease

Hospitalizations/ Surgeries

_____
Patient Name

Review of Symptoms (Circle common problems, add pertinent positives)

Hair loss
Heartburn/Indigestion
Bloating
Hematemesis
Abdominal pain and tenderness
Depression/suicidal ideation
Anxiety
Fainting/dizziness
Palpitations
Complications with pregnancy
Infertility issues
Illicit drug use

Physical Exam

Current Weight (Today). _____ **Previous Weights over the past**

Year: **Date**_____ **weight** _____

Date_____ **weight** _____

Date_____ **weight** _____. LMP _____ (WEIGHT AT TIME OF LOSS, IF NO MENSTRUATION)

T_____ R_____ BP (sitting or lying) _____ BP (standing) _____

P (sitting or lying) _____. P (standing) _____

Height _____.

Please circle: N= Normal A= Abnormal (please describe abnormal)

General **N** **A** _____

HEENT **N** **A** _____

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** (point tenderness at points of impact for exercise -occult fractures) _____

Neuro **N** **A** _____

Breast **N** **A** _____

GU **N** **A** _____

Mentation **N** **A** _____

Assessment

1. **General Physical Health (specifically cardiac status)**

2. **Medical Diagnoses**

3. **Contagious or Infectious Disease**

Plan

1. **Medications (include dosages)** 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 completing the form.
Please fax to: (866) 278-4162