

Nova Luna Center

Eating Disorder Programs

1135 Makawao Ave, PMB# 340

Makawao, HI 96768

Phone: (808) 870-9886 Fax: (808) 878-3315

Physician's Medical Clearance Report

All patients must meet the following criteria:

- 1) Be declared medically stable by Physician (able to safely complete outpatient treatment options).
- 2) PPD/ TB clearance
- 3) Be able to self administer medications prescribed
- 4) Be able to manage any pre-existing medical conditions
- 5) Have no communicable diseases or infections

Patient Name: _____ Date of Birth: _____

Age: _____ M/F: _____ PPD/TB Status / Date: _____

(Please check when completed)

<p><u>For all patients:</u></p> <ul style="list-style-type: none"><input type="checkbox"/> EKG<input type="checkbox"/> CBC with differential, Full Chemistry, Amylase<input type="checkbox"/> Full thyroid Panel<input type="checkbox"/> Urinalysis: specific gravity, sodium<input type="checkbox"/> Bone Density<input type="checkbox"/> Complete Metabolic Profile<input type="checkbox"/> Serum Magnesium <p>(For Adolescent patients, please include a copy of the growth chart)</p>	<p><u>For Patients more than 15% below IBW:</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Chest X-ray<input type="checkbox"/> Complement 3 (C3)<input type="checkbox"/> 24 hour Creatinin Clearance<input type="checkbox"/> Uric Acid<input type="checkbox"/> Echocardiogram<input type="checkbox"/> Bone Density Scan
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(Please attach copies of above tests)

History and Physical

Allergies (Food, Medication, Latex): _____

Medications (OTC, Herbal, Supplements): _____

Prior Medical History: _____

The following Diagnosis are of particular importance to the management of eating disorders, if present please indicate current treatment.

- Diabetes
- Inflammatory Bowel Disease
- Chrons Disease
- Cystic Fibrosis
- Liver Disease
- Gallbladder Disease

Review of Symptoms (please indicate symptoms are present):

<ul style="list-style-type: none"> <input type="checkbox"/> Fatigue <input type="checkbox"/> Sleep Disturbances <input type="checkbox"/> Dizziness/Fainting <input type="checkbox"/> Weakness <input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Depression/Suicidal ideation <input type="checkbox"/> Anxiety <input type="checkbox"/> Loss of Muscle Mass <input type="checkbox"/> hair loss <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Loss of Menses 	<ul style="list-style-type: none"> <input type="checkbox"/> Broken Bones <input type="checkbox"/> Bloating/Heartburn <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Complications with pregnancy <input type="checkbox"/> Infertility problems <input type="checkbox"/> Illicit drug use <input type="checkbox"/> Puffy Cheeks <input type="checkbox"/> Brittle hair/nails <input type="checkbox"/> Heartburn/Indigestion <input type="checkbox"/> Bloating <input type="checkbox"/> Abdominal pain and tenderness
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Physical Findings

Weight Today _____ Height _____ Last Menstrual Period _____

If no menstruation, weight at time of loss

Weight over the last year:

Date: _____ Weight: _____

Date: _____ Weight: _____

Date: _____ Weight: _____

Physical Assessment:

HEENT: _____
NECK: _____
CHEST: _____
LUNGS: _____
HEART: _____
BREASTS: _____
ABDOMEN: _____
BACK: _____
EXTREMITIES: _____
NEUROLOGICAL: _____
SKIN: _____
LYMPH NODES: _____
WORKING DIAGNOSIS: _____

Contagious or Infectious Disease:	Yes	No
Able to manage own medications?	Yes	No

Exercise Limitations:

full light exercise no exercise other light physical limitations

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

DATE: _____ TIME: _____ PHYSICIAN'S SIGNATURE: _____

Phone: _____ Fax: _____