Monte Nido & Affiliates
Treating Eating Disorders

Medical Evaluation for Monte Nido, Oliver-Pyatt Centers and Clementine Programs

The client below is requesting admission to a Monte Nido & Affiliates program for the treatment of an eating disorder.
As their medical provider please complete to the best of your ability and return to: Monte Nido Admissions Fax: 305-424-7448

PATIENT IDENTIFICATION

Name: ____ DOB: _____________ Age: ______ Sex: ______________

ORTHOSTATIC VITALS

Sitting BP: ____________ Sitting HR: ____________
Standing BP: __________ Standing HR: ___________

HEIGHT AND WEIGHT

Height (ft & in.): ___________ Weight (lbs.): _______
Time and Date of Above info: ___________________

CURRENT ED BEHAVIORS *(incl freq. & amount)*

__ Binging: _________________________________
__ Self-induced vomiting: ______________________
__ Laxative use: _______________________________
__ Excessive Exercise: _________________________
__ Calorie restriction: _________________________
__ Other: ____________________________________

CURRENT RISK ASSESSMENT

Suicidal ideation __ Yes __No *(If yes, __ Plan __Intent)*
Suicide attempt __ Yes __No *(If yes, recent date: _____)*
Aggression ideation against others?
__Yes __No *(If yes, __ Plan __Intent)*
Aggression attempt against others
__Yes__No *(If yes, recent date:________)*

COMMUNICABLE DISEASE

(results must be within three months of admission)

Does this client have tuberculosis? __Yes __No
If client has lived / visited outside of the US in the past twelve months, provide details on where and when:

____

If client has other communicable diseases, provide details: ______________________________________

STAT: LABORATORY / DIAGNOSTICS

(required prior to admission to most programs)

__ Comprehensive Metabolic Panel (CMP)
__ Complete Blood Count (CBC)
__ Phosphorous
__ Magnesium
__ HCG (Pregnancy test)
__ Amylase
__ Urine Drug Screen and Alcohol Screening
__ QuantiFERON Gold or TB/PPD form (below)
__ Rubeola and Rubella Titers
__ Growth Charts for adolescents
__ EKG
__ Covid rapid (should be 48 hours prior to admit)

ALLERGIES

Food: ____________________________________
Drug: ____________________________________
Celiac: __Yes __No (*if yes, attach biopsy results*)
Airborne Allergy? __Yes __No (*if yes, attach results*)

OTHER MEDICAL ISSUES/ NUTRITIONAL CONSIDERATIONS

that may impact care of this client.

____
____
____
____
____
____
____

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CURRENTLY PRESCRIBED MEDICATIONS

Please indicate via √ which medication(s) ARE PRESCRIBED by the Physician COMPLETING Medical Clearance.

√	Psychotropic Medications	Dosage	Frequency	Indication
√	**OTHER Pertinent Medications**	**Dosage**	**Frequency**	**Indication**

Is this client able to be compliant with medication(s) in an unstructured outpatient setting? __Yes __No

Is this client able to self-administer medication(s)? __Yes __No

Physician Signature: ________________________________ Date: ________________________

Physician Name and Credentials, Address, Email and Telephone Number: (stamp is acceptable):

TB/PPD Test for Monte Nido, Oliver-Pyatt Centers and Clementine Programs

The client below is requesting admission to a Monte Nido & Affiliates program for the treatment of an eating disorder.
Please order and note results of TB/PPD test and return to: Monte Nido Admissions Fax: 305-424-7448

PATIENT IDENTIFICATION

Name: ____ DOB: _____________ Age: ______ Sex: ______________

TB/PPD TEST

Manufacturer: ____________________ Lot #: _________ Exp. Date: ________ Tuberculin Dose Used: __________

Mantoux Test Placed: __ Left Arm __ Right Arm Test Placed by: _______________ Date of Test: ______________

TB TEST READ

Reading Mm Duration: ____________ Reading Description: ____________________ Test Read By: __________

Results: ___ Positive ____Negative

CHEST X-RAY (IF APPLICABLE)

Results: ___Positive ___Negative Date: ______________