Dear Physician:

La Luna Center provides comprehensive eating disorder treatment for those struggling with anorexia nervosa, bulimia nervosa, binge eating disorder, compulsive exercising and concurrent mood disorders. We have two locations: Boulder and Fort Collins. We offer three levels of care: Outpatient, Partial Hospitalization Program (PHP: 6 hrs per day, 5 days a week) and an Intensive Outpatient Program (IOP: 3 hrs per day, 3 days a week).

Clients that attend our programs must be medically stable; although there may be signs/degree of medical compromise related to eating disorder behaviors. If you find this patient to be medically unstable, we will recommend inpatient or residential level of care until he/she is stabilized.

_____ has applied for admission to our program and has listed you as her/his primary care physician. We hope that as the patient's primary care physician, you are willing to provide us with necessary information regarding medical history and current status. We rely on your assessment as 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 continued 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) Be able to self-administer medication
3) Be able to manage pre-existing medical conditions
4) Be free from any infectious or contagious diseases

Patient Name _____DOB ____/_____/_____ M/F_____

Please attach copies of the following tests or have them forwarded to the enclosed address:
(All tests are required, unless otherwise indicated by ~~strikethrough~~)

- Chemistries (Chem 20)
- CBC with diff
- TSH, zinc, vitamin D
- UA and Drug Screen
- Pregnancy Test
- EKG
- Nuclear Medicine Bone Density Scan (i.e. DEXA / DXA)

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
- Crohn's 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
- Hematemesis
- 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)
_____

Lymph N/A_____

Musculo/Skel N/A_____

Neuro N/A (point tenderness at points of impact for exercise –occult fractures)
_____

Breast N/A_____

GU N/A (within past year) _____

Mentation N/A_____

Assessment

1. General Physical Health (especially cardiac status)
2. Medical Diagnoses:

3. Contagious or Infectious Disease yes / no

Plan

1. Medications (include dosage)

   Able to manage own medications yes / no

2. Exercise Limitations

   □ Full □ Light Exercise □ No Exercise □ other physical limitations

   Specifications: _____

3. Other recommendations, follow-up, or referral

   _____

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

_____ _____
Name of Physician Address

_____ _____ _____
Signature Date Phone/Fax

This report can be faxed to 303-200-7098 for both Boulder and Fort Collins patients.

Thank you for your cooperation.