Empower WELLNESS, PC

*PLEASE MAKE AN APPT WITH YOUR MEDICAL PROVIDER TO ORDER THE TESTS BELOW TO DETERMINE MEDICAL STABILITY FOR OUTPATIENT SERVICES. THANK YOU!

Patient Name:
Patient's Date of Birth:

Please be advised that your patient is seeking outpatient therapy for their eating disorder. The below evaluation is necessary to determine medical stability to continue being seen on an outpatient basis.

1. **Electrocardiograph (EKG)** – with your primary care physician's interpretation.
2. **Required Laboratory Tests**
   a. CBC with differential and platelets
   b. Urinalysis
   c. Comprehensive Metabolic Panel (Chemistry Screen) – must include the following:
      - Glucose
      - Potassium
      - CO2
      - Creatinine
      - Albumin
      - Phosphorus
      - Total Protein
      - Total Bilirubin
      - AST (SGOT)
      - ALT (SGPT)
      - Alkaline Phosphatase
      - Sodium
      - Chloride
      - BUN
      - Calcium
      - Magnesium
   d. Serum tests (not included in most Comprehensive Metabolic Panels)
      - Magnesium
      - Serum HCG
      - TSH
      - Phosphorus
3. Vitals: Blood Pressure, Height and Weight

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PLEASE GIVE THIS FORM TO YOUR PRIMARY CARE PROVIDER TO COMPLETE. THANK YOU.

CLIENT NAME: (PRINT) _____ *DOB*_____ *AGE*_____

1. PRESENT ILLNESSES/COMPLAINTS: _____

_____

_____

2. PAST MEDICAL HISTORY (please include surgeries and use back of this form if necessary):

_____

_____

_____

3. BLOOD PRESSURE: SITTING: _____ STANDING: _____ (WE NEED BOTH, PLEASE)
4. PULSE: SITTING: _____ STANDING:_____ (WE NEED BOTH, PLEASE)

   HEIGHT: _____ WEIGHT: _____
5. ALLERGIES _____
6. CURRENT MEDICATIONS (include dosages and frequency):

MEDICATION (dose, times, etc.)	MEDICATION (dose, times, etc.)	MEDICATION (dose, times, etc.)

7. PHYSICAL EXAM/REVIEW OF SYSTEMS:

Skin	
HEENT	
Neck	
Breasts	
Respiratory	
Cardiac	
Gastrointestinal	
Genitourinary	
Peripheral Vascular	
Musculoskeletal	
Neurological	

8. MEDICAL DIAGNOSES: _____

_____

9. IS THE PATIENT MEDICALLY STABLE FOR OUTPATIENT MENTAL HEALTH TREATMENT: YES _____ NO _____

   If No Please Explain:

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