Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

3240 Burnt Mill Drive ▪ Suite 1 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

IOP Referral Form - Physician

Every client is required to undergo a physical/medical health screening prior to admission with a qualified medical professional within two weeks of expected admission date:

Client Name:_____

DOB:_____ Sex: M F Gender: _____

Referring provider name, facility: _____

Office Address: _____

_____

Phone:_____ Fax:_____ Email: _____

Physical Exam

Height:_____ft_____in (**Blind**) Weight_____lbs. BMI_____

*Any client with significant eating disorder symptoms (weight below 80% of IBW, medical complications of malnutrition or purging, etc.) will require medical clearance from their doctor verifying that they are safe to be in the program. The information will be reviewed by our staff prior to admission.

	Lying	Standing
Blood pressure: **(orthostatic**)	_____/_____	_____/_____
Pulse**: (orthostatic**)	_____	_____

RR:_____ Temp:_____

HEENT: _____

_____

Dental:_____

Thyroid:_____

Chest/Lungs: _____

_____

Breasts:_____

Heart:_____

_____

Abdomen:_____

_____

Pelvic/Rectal:_____

_____

Skin/Hair/Nails:_____

Musculoskeletal:_____

Neurological:_____

Extremities/Edema:_____

_____

Allergies:_____

_____

IOP REFERRAL FORM - PHYSICIAN

Client Name: _____

Current Diagnosis: _____

_____

Current Symptoms: _____

_____

Current medications (including dose and frequency): _____

_____

Medical problems and treatment: _____

_____

Substance use/abuse: _____

_____

Risk assessment (SI, SIB, etc.): _____

Requirements for IOP Admission:

Is the patient ambulatory? Yes No

Details: _____

Can the patient manage her/his own medications? Yes No

Details: _____

Are there any limitations on physical activities? Yes No

Details: _____

Does the client have any history of or current communicable diseases? Yes No

If no, can the patient still be admitted with necessary precautions to the intensive outpatient program? Yes No

Details: _____

The following tests are **required** prior to the patient's admission; **please forward copies:**

- **Documentation of specific allergen testing is required for food allergies if exclusion is recommended**
- CBC with differential
- Chemistry panel comprehensive
- TSH, T3, Total T4
- Amylase, Lipase
- Magnesium
- Phosphorous
- EKG
- Urine HCG (if indicated)
- Vit D, Vit B12 (if indicated)
- Hepatitis A screen/documentation (if indicated)
- Drug Toxicology Screen (if indicated)

Additional information/comments: _____

_____

_____

_____

_____

I hereby certify that _____ the above-named client is medically stable and meets all requirements for admission to an IOP.

Physician Name: _____

Physician Signature: _____ Date: _____