230 Pottersville Road
Chester, New Jersey 07930
Fax number: 908.888.2208

PRE – ADMISSION MEDICAL CLEARANCE FORM

Please complete this form and attach most recent semiannual dental exam records, immunization forms and growth charts (for patients 18 and under) so that we can complete our preadmission screening. Please ensure that you bring at least 2 weeks of any prescribed medications for admission. Thank you.

Patient Name: _____Date of Birth: _____

Provider name and credentials completing the form:_____

Exam Date: _____

ED Diagnosis: ____Anorexia Nervosa ____Bulimia Nervosa ___ARFID ____BED ___OSFED

General:_____
_____
_____

Height:_____ **Weight:_____** **Temp:____**

Please obtain lying and standing blood pressure and pulse if clinically indicated.

Pulse

Lying:_____ Sitting: _____ Standing: _____

Blood Pressure

Lying:_____ Sitting: _____ Standing: _____

Skin: WNL___

Heent : WNL___

Cardiac : WNL___

Lungs :WNL___

Abdomen :WNL___

Extremities: WNL___

Neuro: WNL__

GU:WNL___

Date of last PAP, if indicated _____

Does patient have any complaints of physical pain? If yes describe:

_____
_____
_____
_____

History of re-feeding syndrome, lower leg edema, cardiac conditions?

_____
_____

Summary:_____
_____
_____
_____
_____

Pre-admit Laboratory tests please fax all results to: **908. 888.2208**

EKG
CBC with Diff.
CMP /MAGNESIUM/PHOSPHORUS, AMYLASE, LIPASE, TSH, THYROID PROFILE
URINALYSIS
SERUM HcG
VITAMIN D LEVELS

URINE PREGNANCY TEST **(if available)**

COVID RAPID or PCR TEST (TO BE COMPLETED WITHIN 48 HOURS OF ADMISSION)

QUANTIFERON TB GOLD

Last flu vaccination date: _____/_____/_____

Would patient be willing to have a flu vaccine administered while at Hidden River?

Circle: YES NO

Would patient be willing to have a COVID vaccine and/or booster administered while at Hidden River?

Circle: YES NO

Food Allergies:

_____

Type of allergy testing used to confirm:

_____

In the interest of accuracy, we require that any reported food allergies be accompanied by validated testing (oral challenge, skin prick, serum IgE antibodies, biopsy) by a physician. **We cannot accommodate food allergies without proper testing, so please provide appropriate documentation.**

Medical Problems:

_____

_____

_____

Medications:

_____

_____

_____

Allergies (does patient require a use of a Epi-pen):

Yes__ No__

Is patient free from communicative diseases:

_____

_____

_____

Physician/Practitioner (printed)	Physician/Practitioner (signature)	Date

Office phone: _____
Office fax: _____

Hidden River Eating Disorder Treatment
230 Pottersville Road
Chester , New Jersey 09730
Phone (908) 895 – 4931
Fax (908) 888-2208