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

# Pre-Admission Psychotropic Medication Form

Date:_____

Dear MD/DO:_____ or NP:_____

Your patient is scheduled to be admitted to Hidden River Eating Disorder Treatment 24 hour residential facility. To help ensure treatment continuity, please complete this form and fax back to us at your earliest convenience.

Thank You,
The Hidden River Treatment Team
**Main Phone:** (908) 895 - 4931
**Fax:** 908. 888.2208

Director of Business Development & Admissions
Jennifer Vargas
**Phone:** (908) 895 – 4931 ext. 203
**Fax:** 908. 888.2208

| **Patient:** | **Diagnosis:** |
|---|---|
| **DOB:** | **Allergies** |

## Psychotropic Medication List

| Medication | Ordered by Prescriber (Please initial) | Dosage | Doses per 24 Hours | Indication |
|---|---|---|---|---|
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Physician/Practitioner (printed) Physician/Practitioner (signature) Date

Office phone: _____
Office fax: _____

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