monte nido

Medical Evaluation

The client below is requesting admission to a Monte Nido program for the treatment of an eating disorder. As their medical provider, please complete to the best of your ability and send to our Admissions department with lab work and other relevant supporting documentation.

Phone: (888) 228-1253 · Fax: (305) 424-7448 · Admissions@MonteNido.com

PATIENT IDENTIFICATION

Exam Date:

Name:

Date of Birth:

Age:

Sex:

ORTHOSTATIC VITALS

Sitting BP: Sitting HR:

Standing BP: Standing HR:

HEIGHT AND WEIGHT

Height: ft. in. Weight: lbs.

Date of Measurement:

ALLERGIES

Food and drug: YES ☐ NO ☐
(If yes, please explain)

Airborne Allergy?:
(if yes, attach results) YES ☐ NO ☐

MEDICAL CONDITIONS

Type 1 or type 2 diabetes? *(If yes, attach hemoglobin A1C and glucose logs for the past two weeks.)* YES ☐ NO ☐

Celiac disease?
(If yes, attach biopsy results) YES ☐ NO ☐

Other medical/nutritional considerations:

If client has communicable disease(s) or open wounds, provide details:

CURRENT EATING DISORDER BEHAVIORS

(Include frequency & amount of restricting, bingeing, purging, excessive exercise, etc)

CURRENT RISK ASSESSMENT

Suicidal ideation

☐ Yes *If yes: Plan* ☐ *Intent* ☐

☐ No

Suicide attempt

☐ Yes *If yes, most recent attempt:* _____

☐ No

Aggressive thoughts toward others?

☐ Yes *If yes: Plan* ☐ *Intent* ☐

☐ No

Aggressive behavior toward others?

☐ Yes *If yes, most recent attempt:* _____

☐ No

LABORATORY / DIAGNOSTICS

(Required prior to admission to most Inpatient and Residential programs.)

- ☐ Comprehensive Metabolic Panel (CMP)
- ☐ Complete Blood Count (CBC)
- ☐ Phosphorous
- ☐ Magnesium
- ☐ HCG (Pregnancy test)
- ☐ Urine Drug Screen
- ☐ QuantiFERON Gold or TB/PPD form
- ☐ Rubeola and Rubella Titers
- ☐ Growth Charts for adolescents
- ☐ EKG

IS THIS CLIENT ABLE TO:

Self-administer medication(s)? YES ☐ NO ☐ Complete ADLs independently? YES ☐ NO ☐

CURRENTLY PRESCRIBED MEDICATIONS *(Attach additional medications)*

Medication Name	Dosage	Frequency	Indication

_____ _____

Provider (MD/NP/PA) Signature **Date**

PROVIDER DETAILS *(Provider Name and Credentials, Address, Email, Telephone Number* - STAMP IS ACCEPTABLE)

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TB/PPD Test

Date:

Required If Admitting to Oregon or Arizona Inpatient and Residential Programs Unless QuantiFERON Gold Collected (for AZ and OR)

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PATIENT IDENTIFICATION

Name: Date of Birth:

Age: Sex:

TB/PPD TEST

Manufacturer: Lot #: Exp. Date:

Tuberculin Dose Used: Mantoux Test Place: Left Arm ☐ Right Arm ☐

Test Placed By: Date of Test:

TB TEST READ

Reading mm Duration: Reading Description:

Test Read By: Results: POSITIVE ☐ NEGATIVE ☐

CHEST X-RAY (IF APPLICABLE)

Date: Results: POSITIVE ☐ NEGATIVE ☐