Medical Clearance & Permission Form

For the Healthy Futures Eating Disorder Intensive Outpatient Program

To Be Signed By Patient's Primary Care Physician

I certify that _____ is in good medical standing to participate in an outpatient eating disorder program two to four days per week, three hours each day and does not require further medical treatment that would preclude participation (tube feeding, rehydration, I. V.'s to balance electrolytes, etc.)

Date of most recent office visit_____ Date of most recent labs_____

_____normal or _____abnormal (what levels) _____

If abnormal, what is the prescribed treatment? _____

Date of most recent EKG _____normal or _____abnormal

Restrictions/Recommendations to diet, exercise, work, other? _____

I plan on following this patient on a regular basis as needed. YES NO

I am available to consult with if needed at _____
Telephone number

_____ _____
Physician's Signature Date

_____
Physician's Printed Name

Practice Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Practice Email: _____

Please fax to: Healthy Futures, 480-451-8510
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