Atlanta
Center for
Eating Disorders

4536 Barclay Drive Dunwoody, GA 30338 (770) 458-8711 fax (770) 458-8640

ACE Medical Clearance Form

PATIENT:_____ DATE:_____

The above named patient is being assessed and is seeking treatment on an outpatient basis at the Atlanta Center for Eating Disorders (ACE). ACE is not a medical facility, however, this patient is in need of medical attention and a determination that (s)he is not in need of immediate inpatient treatment and thus is safe to be treated as an outpatient. We will require that (s)he have regular contact with a physician to follow any physical problems that may arise. If you are willing to follow her/him as a patient, please sign below. If you have any reservations about her/his treatment at ACE, please indicate on the lines below. We will be in contact with you as treatment continues. Please contact us if we can be of any further assistance or if you have any concerns about this patient's treatment.

We are requesting the following medical information as part of our admission/intake screening:

1. Recent H&P (history and physical)
2. Orthostatic vitals **lying HR: ___ BP: __/__ sitting HR: ___ BP: __/__ standing HR: ___ BP: __/__**
3. EKG
4. Growth chart for children/adolescents (<18 years old)
5. Height and Weight (blind, in gown, post-void) and weight history
6. Lab work to include CBC with diff/platelets, TSH, free T4, ESR, CMP with Mg & Ph
7. Additional lab work if indicated: serum amylase if recent purging history

Please fax requested tests and reports to ACE at 770-458-8640.
Please also include any concerns or recommendations to repeat labs/tests, follow up appointments, etc.

_____ I am willing to work with this patient and I recommend that (s)he be treated on an outpatient basis at the Atlanta Center for Eating Disorders.

_____ I recommend that (s)he be treated on an outpatient basis at the Atlanta Center for Eating Disorders but I will not continue to follow this patient. I am recommending that this patient see his/her primary medical provider for continued follow up.

_____ I do not recommend treatment at ACE and/or I am not willing to treat this patient. (Please explain)

_____

_____

_____

_____
Physician's Name (print)

_____ _____
Physician's Signature Date