

Gwen Schubert Grabb, MFT
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Medical Clearance Form

Re: _____ DOB: _____ Date: _____

Dear _____,

The patient named above is a client in my private practice. Patients must be medically stable to participate in outpatient therapy otherwise a higher level of care is necessary. Please examine the patient and complete the following certification. It can be very triggering for eating disorder patients to know their weight. I ask them to allow members of the "treatment team" to weigh them with their back to the scale and not disclose the number. Please fax this form directly to me at the above number. Thank you so much for your time and sensitivity.

Date of Exam: : _____

Presenting Diagnosis			
Other Significant Medical Problems			
Medications	/Dosage:	/Dosage:	/Dosage:
	/Dosage:	/Dosage:	/Dosage:
Physical Exam	Height:	Weight:	Temp:
Orthostatic Measurements	Supine Blood Pressure:		Standing Blood Pressure:
	Supine Pulse:		Standing Pulse:
Last Menstrual Period	Date:	In the last 6 months has clients missed more the 3 consecutive periods?	__YES __NO
Abnormal Findings on Medical Exam			

In addition to any tests you deem necessary, please perform the following tests as recommended by the Academy for Eating Disorders.

REQUIRED LABS

Complete Blood Count Comprehensive Metabolic Panel (including electrolytes) TSH Urinalysis

OPTIONAL LABS (Test on an as-needed basis.)

Amylase Hormone Panel Electrocardiogram

I have examined this patient and certify that he/she is medically stable and able to enter outpatient therapy with Gwen Schubert Grabb.

Signature: _____ Date: _____