Monte Nido & Affiliates
Monte Nido Walden Rosewood Clementine

MonteNidoAffiliates.com

Exam Date: / /

Medical Evaluation

The client below is requesting admission to a Monte Nido & Affiliates program for the treatment of an eating disorder. As their medical provider, please complete to the best of your ability and fax to our Admissions department at **(305) 424-7448**.

ADMISSIONS: (888) 228-1253 • Fax: (305) 424-7448 • Admissions@MonteNidoAffiliates.com

PATIENT IDENTIFICATION:

Name: _____ DOB: ____/____/_____ Age: _____ Sex: _____

ORTHOSTATIC VITALS

Sitting BP: _____ Sitting HR: _____

Standing BP: _____ Standing HR: _____

HEIGHT AND WEIGHT

Height: _____ ft. _____ in. Weight: _____ lb.

Date of Measurement: _____/_____/_____

CURRENT ED BEHAVIORS *(Incl. freq & amt)*

- ☐ Binging: _____
- ☐ Self-induced vomiting: _____
- ☐ Laxative use: _____
- ☐ Excessive exercise: _____
- ☐ Calorie restriction: _____
- ☐ Other: _____

CURRENT RISK ASSESSMENT

Suicidal ideation

☐ Yes *If yes:* ☐ *Plan* ☐ *Intent*
☐ No

Suicide attempt

☐ Yes *If yes, recent date:* ____/____/_____
☐ No

Aggressive thoughts toward others?

☐ Yes *If yes:* ☐ *Plan* ☐ *Intent*
☐ No

Aggressive behavior toward others?

☐ Yes *If yes, recent date:* ____/____/_____
☐ No

COMMUNICABLE DISEASE

Does this client currently have COVID-19? ☐ Yes ☐ No

Does this client have tuberculosis? ☐ Yes ☐ No

If client has lived / visited outside of the US in the past 12 months, provide details on where and when:

_____

If client has other communicable diseases or open wounds, provide details: _____

_____

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 *(OR and AZ only, see pg. 3)*
- ☐ Rubeola and Rubella Titers
- ☐ Growth Charts for adolescents
- ☐ EKG

ALLERGIES

Food: _____

Drug: _____

Celiac: ☐ Yes ☐ No *(If yes, attach biopsy results)*

Airborne Allergy? ☐ Yes ☐ No *(If yes, attach results)*

OTHER MEDICAL ISSUES/ NUTRITIONAL CONSIDERATIONS that may impact care of this client:

CURRENTLY PRESCRIBED MEDICATIONS

PSYCHOTROPIC MEDICATIONS

Medication Name	Dosage	Frequency	Indication

OTHER MEDICATIONS

Medication Name	Dosage	Frequency	Indication

IS THIS CLIENT ABLE TO:

Self-administer medication(s)? ☐ Yes ☐ No

Complete ADLs independently? ☐ Yes ☐ No

_____ ____ / ____ / _____

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

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

The client below is requesting admission to a Monte Nido & Affiliates program for the treatment of an eating disorder. Please order and note results of TB/PPD test and fax to our Admissions department at **(305) 424-7448**.

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PATIENT IDENTIFICATION:

Name: _____ DOB: ____/____/_____ Age: _____ Sex: _____

TB/PPD TEST

Manufacturer: _____ Lot #: _____ Exp. Date: ___/___

Tuberculin Dose Used: _____ Mantoux Test Placed: ☐ 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