Dear Physician:

Focus provides Intensive Outpatient Treatment for Eating Disorders. The program is designed for patients who suffer from Anorexia Nervosa, Bulimia Nervosa, Binge-Eating and related disorders. Focus does accept those with stabilized co-occurring psychiatric conditions such as Substance Dependence, Bipolar Disorder, Depressive Disorders and Anxiety Disorders.

Intensive Outpatient (IOP) treatment for eating disorders is intended for patients who are appropriate for outpatient level of care and are also seeing other outpatient providers. The patients should be medically stable and not require any high-level medical monitoring, procedures or interventions such as those provided in a hospital level of care i.e., tube feeding, intravenous fluids, or cardiac monitoring. Please note that Focus provides treatment for mental health under the supervision of a psychiatrist, with leadership from licensed counselors, therapists, and dietitians. In addition to psychotherapy-based group work, each patient's food, weight, and eating disorder behaviors are monitored individually by a registered dietitian. Our staff would like to stay in touch with you on your patient's progress, as you will continue to serve as the primary medical team member during IOP treatment.

___________________________________ has applied for admission to our program. We would be appreciative if you, as her primary care provider, would be willing to provide us with necessary information regarding her medical history and current medical condition. The results of your examination, along with all tests and lab findings are considered an important part of our admissions process. In addition, the ability to collaborate and communicate with you throughout your patient's treatment course with us is considered to be a crucial element of the multi-disciplinary eating disorder treatment process.

Enclosed is our medical clearance form. Should you have any questions or need any further information, please call us at 865-622-7116. Thank you in advance for your cooperation.

Please return these documents and labs/EKG by fax to 865-622-2740.

Focus Integrative Centers
Intensive Outpatient Program for Eating Disorders
Phone (865) 622-7116 Fax (865) 622-2740
www.FocusIntegrativeCenters.com

MEDICAL CLEARANCE FORM

These are the Laboratory tests that are required in order for the patient to be medically cleared for admission:

CBC w/diff, CMPw/GFR, Magnesium, Phosphorus, Calcium, TSH with reflex to Free T4, Serum Pregnancy, UA, Amylase, Lipid Panel, EKG with Interpretation, Medication level if needed.

*******These labs should be no older than 30 days*******

Hgb A1 C for Diabetics (No older than 90 days)

Additional labs that may be indicated, but that are not required for admission include Complement Component 3, Vitamin D3, Ferritin, Folate, B-12, and Zinc. For patients with amenorrhea, the following hormones may be considered - serum luteinizing and follicle-stimulating hormones, serum prolactin, and serum estradiol

VITALS/WEIGHT

Weight In Gown Today: ______________ Height:______________

Previous weights over past year, if known:

Date:______________ Weight:____________

Date:______________ Weight:____________

Vital Signs

BP supine:_______________ Pulse supine: ______________ Temp:___________

BP standing:_____________ Pulse standing:_____________

LMP: __________________ If no menstruation, weight at time of loss_________

Past Medical History :____

____

PHYSICAL EXAM

Please circle: **N**=Normal **A**=Abnormal Please describe abnormal findings

HEENT (alopecia, parotid/salivary swelling, enamel erosion, h/o esophageal tears) N / A :

____

Chest (presence of muscle wasting) N / A:_________________________________

Heart (murmurs, bradycardia) N / A:_______________________________________

Lungs N / A:____

Abdomen N / A:____

Skin (Lanugo, acrocyanosis) N / A:_______________________________________

Lymph N / A:____

Musculo/Skel N / A:____

Neurological N / A: ____

GU (within past year) N / A:____

General Overall Physical Health:____

Current Medical Diagnosis: ____

Was there any problem identified today that would necessitate medical follow-up after treatment of the Eating Disorder? ___________________________________

____

Is there any information that you have that would be helpful for us to know with regard to treatment planning?

____

____

After completion of the physical examination, review of the labs and EKG, I find this patient to be medically stable for treatment in an intensive outpatient setting.

___________________________ ______________________________

Name of Physician Address

____________________________ _________ _______________________

Signature Date Phone/Fax

Thank you for your cooperation.

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, ______________________________, DOB: _____________, SSN: __________________ authorize **Focus Integrative Centers, 2210 Sutherland Ave, Suite 115, Knoxville, TN 37919**, to RELEASE OR OBTAIN information contained in my medical record. This information may be ____ RELEASED TO or ____ OBTAINED FROM the following:

Name: ____

Address: ____

Phone: _______________________________ Fax: ______________________________

Dates of Treatment to be released: ______________to ______________

The information is being released for the following reason: ______________________________

Revocation: I understand that I have the right to revoke this authorization in writing at any time by sending written notification to Focus Medical Records Custodian, 2210 Sutherland Ave, Suite 115, Knoxville, TN 37919. I understand that a revocation is not effective to the extent that action has been taken in reliance on the authorization.

Information to be released: (Required) Only specific information will be released. Patient must check information to be released. May check multiples.

___Verify Admission/Discharge	___Dr Orders/Notes	___Aftercare plan
___Discharge Summary	___Medications	___Treatment plan reviews
___History and Physical	___Labs/UDS	___Psychiatric consult/evaluation/notes
___Admission Assessment	___Nursing Assessment	___Progress in Treatment

___Other ____

Form of Disclosure: Unless I have specifically requested in writing that the disclosure be made in a certain format, Focus reserves the right to disclose information as permitted by this authorization in any form that is deemed to be appropriate and consistent with the applicable law, including verbal, in paper format or electronically.

Re-Disclosure: The recipient of this information may not disclose this information unless authorized by me or unless such disclosure is required or permitted by law 42 CFR, part 2. I understand that once the information is disclosed the HIPAA Privacy Regulations may no longer protect it should the recipient re-disclose it. I further agree to hold harmless Focus and its staff and agents from all legal liability that may arise from the release of information herein requested.

This medical record contains information which is privileged and confidential remarks furnished by the patient, patient's family and staff. Records will contain alcohol and drug treatment information and may contain AIDS/HIV and/or psychiatric/psychological and/or mental health privileged information.

Expiration: Unless sooner revoked, this consent expires in one year from the date it was executed and signed, unless otherwise indicated here ____________________. I understand that I may receive a copy of this authorization upon my request.

This authorization to obtain and/or release information is fully understood and is voluntary on my part.

Patient signature and date: (Required) ____

Witness signature and date: (Required) ____