Patient Name:

Medical Clearance Form

Patient DOB:

Date of last appointment: Date of next appointment:

*Please confirm that you have included the following required records for review in this fax:*

□ **Most recent medical visit note with physical exam**

□ **Comprehensive Metabolic Panel** (including **potassium**, **phosphorus** and **magnesium**)

□ **Complete Blood Count**

□ **Electrocardiogram**

□ **Full vital signs** (including **orthostatics** and **temperature**)

🞎 cm

🞎 in

🞎 kg

🞎 lbs

 *Weight*: *Height*:

 *Supine HR*: *Supine BP*:

 *Standing HR*: *Standing BP*:

□ **Updated growth charts** (BMI-for-age, weight, and height)

□ **List of medications**

□ **OPTIONAL**: Other analyses/exam *(please specify):*

**Please indicate whether this patient is medically stable:**

* **Yes**, based on my review of the aforementioned analyses and physical examination, I deem this patient medically stable to engage in outpatient treatment.
* **No**, based on my review of the aforementioned analyses and physical examination, this patient requires constant medical monitoring and will be referred for intensive medical monitoring inpatient treatment. This patient is NOT medically stable to engage in outpatient treatment at this time.

Signature of Physician: Date:

Physician’s Name:

Phone: Pager/Cell:

Fax: Email: