



**La Ventana Eating Disorder Programs
Medical Clearance Form**

Southern California: 275 E. Hillcrest Dr. #120, Thousand Oaks, CA 91360
Tel: 805-777-3873 | Fax: 805-777-3874

Northern California: 3150 California St. #6, San Francisco, CA 94115
Tel: 415-345-1238 | Fax: 415-345-8613

Please Fax La Ventana any RECENT progress notes and lab results.

Furthermore, please fill out this form and let us know if the patient appears medically stable for our outpatient program.

/ /

Patient Name

Date of Birth

Do you feel the patient is medically stable enough to participate in our outpatient program?

Yes

No

Do you believe patient medically necessitates hospitalization?

Yes

No

Physical Examination:

General: _____

Temperature: _____

Height: _____

Weight: _____

Please Assess for Orthostasis:

Blood Pressure (supine): _____

Heart Rate (supine): _____

Blood Pressure (standing): _____

Heart Rate (standing): _____

Are these criteria met?

___ Minimum resting heart rate of 45 but not greater than 100

___ Minimal orthostatic change in blood pressure (BP) and heart rate (HR) from supine to standing position

Additional Comments: