The Lotus Collaborative
603 Mission Street, **Santa Cruz**, CA 95060
Phone: 831-600-7103 **Fax:** 831-600-7499

1610 Union Street **San Francisco**, CA 94123
Phone: 415-931-3731 **Fax:** 415-931-3739
www.thelotuscollaborative.com

Dear Physician,

_____ has applied for admission to **The Lotus Collaboratives** *(Location)*_____ intensive eating disorder treatment program and has listed you as their primary care physician. We hope that, as their primary care physician, you are willing to provide us with necessary information regarding this patient's medical history and current status. The results of your examination, along with all tests and lab findings, will be reviewed by our treatment team and is considered an essential part of our admissions procedure.

Our intensive recovery program is designed for patients who suffer from serious problems with anorexia, bulimia, compulsive overeating, compulsive exercising and concurrent mood disorders. Clients that attend our programs must be medically stable. If you find this patient to be medically unstable, we would recommend eating disorder inpatient or residential level of care until stabilized.

We have two locations: Santa Cruz and San Francisco, CA. We offer three levels of care: outpatient, a Partial Hospitalization Program (PHP: 6-8 hrs a day, 5-7 days a week) and an Intensive Outpatient Program (IOP: 4.5 hrs a day, 3-7 days a week). We are not a medical facility and we rely on the treating medical providers to ensure medical stability and supervision of patients' health. Insurance companies mandate that patients attending PHP are seen once a week for ongoing medical clearance, and once a month for those attending IOP treatment.

Enclosed is the clinical data form required for medical clearance. Should you have any questions or need any further information, please call us at: **415-931-3731** to reach our San Francisco location **;** or **831-600-7103** to reach our Santa Cruz location.

At The Lotus Collaborative we consider the primary care physician a critical and valued member of the treatment team and welcome your input into patient care. Thank you in advance for your cooperation.

Sincerely,
The Lotus Collaborative Treatment Team

Physician's Report for The Lotus Collaborative Medical Clearance

San Francisco Fax: 415-931-3739 Santa Cruz Fax: 831-600-7499

Patient Name _____ **DOB** / /

Patient must meet the following criteria:

1) Be declared medically stable by a physician to receive treatment in PHP/IOP programs
2) Be able to self-administer medication
3) Be able to manage existing medical conditions
4) Be free from any infectious or contagious diseases

Please attach copies of the following tests or have them forwarded to the enclosed address:

1) Chemistries (Chem 20)
2) UA
3) CBC with diff
4) EKG
5) Pregnancy test
6) TSH/ Thyroid screen
7) For an adolescent patients, please include a copy of the growth curve
8) Is a Dexa scan indicated for this patient? No/Yes (if so, date scheduled:_____)

Eating Disorder Symptoms (circle common problems, add pertinent positives)

- Calorie counting, continuous dieting, rigid food selection, fear of weight gain
- Rapid weight loss or gain, inability to gain weight, addicted to exercising, purging
- Loss of control when eating, using food to cope or soothe, secretive eating
- Overuse of sweets, carbs, or favorite/feared foods, excessive focus on "healthy eating"

Medical History

The following are of particular importance in the management of eating disorders. Document positives:

- Electrolyte Imbalances
- Irregular Labs
- Orthostatic Hypotension or POTS
- Substance Abuse
- Hypo/Hypertension
- Brady/Tachycardia
- Amenorrhea
- Polycystic Ovarian Syndrome
- Edema
    - Abuse of laxatives, diuretics, and/ or diet pills
    - Hypo/Hyperthyroid
    - Gastroesophageal Reflux Disease (GERD)
- Gastroparesis
- Gastritis
- Pseudo Bartter Syndrome Diabetes Type 1 or Type 2
- Inflammatory Bowel Disease
- Liver Disease/ Fatty Liver Infiltrate
- Gallbladder Disease

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History of Physical or Mental Health Hospitalizations:

History of Mental Health Care and providers names:

History and Physical

_____

Tested and Documented Food or Drug Allergies

_____

Medications (Rx, OTC, herbs and supplements)

Review of Current Symptoms (circle common problems, add pertinent positives)

- heartburn/indigestion
- hematemesis
- nausea
- bloating
- abdominal pain and tenderness
- diarrhea
- constipation
- depression/suicidal ideation
- anxiety
- fainting/dizziness
- hair loss
- palpitations
- complications with pregnancy
- infertility problems
- illicit drug use
- edema
- Other:

Physical Exam (Please weigh patient backwards and do not disclose weight)

Weight Today _____
Measured Height _____
BMI _____

Previous weights over past year:
Date _____ Weight_____
Date _____ Weight_____
Date _____ Weight_____

(For adolescents only) BMI % _____

Date of Last Menstrual Period ____/___/_____

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Temp_____ RR_____

____ BP (sitting)
____ BP(standing max 1 minute later)
____ P (sitting)
____ P (standing max 1 minute later)

The Lotus Collaboratives Protocol for abnormal vitals
We define orthostasis as:
Decrease in Systolic pressure (first number) from sitting to standing by **20**
OR Decrease in Diastolic pressure (second number) from sitting to standing by **10**
OR Rise in pulse by **20** beats per minute

If client is orthostatic our protocol is to call and seek guidance from your office. If you'd prefer we first follow an individualized protocol for this patient please fill out the following:
Please state the blood pressure under/over which you would like the patient sent immediately to Urgent Care:
Under _____ this client is advised to go to Urgent Care
Over _____ this client is advised to go to Urgent Care

Please state the heart rate under/over which you would like the patient sent immediately to Urgent Care:
Under _____ bpm, this client is advised to go to Urgent Care
Over _____ bpm, this client is advised to go to Urgent Care

Please name any other specific instructions related to heart rate and blood pressure, including any further directions related to orthostasis:

_____

_____

_____

Please check if normal, describe if abnormal:

General		Parotid swelling	
Hair		Chest	
Heart		Lungs	
Abdomen		Lymph	
Neuro		Breast	

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GU (within past year) _____

Skin (lanugo, yellow palms and soles, jaundice, callus on fingers, acanthosis nigricans)

_____

Musculo/Skel (point tenderness at points of impact for exercise –occult fractures)

_____

Assessment and Plan

1. General Physical Health (in particular, cardiovascular status)

2. Medical Diagnoses

3. Medications (include dosage)

4. In the event our treatment team deems this patient psychologically cleared to exercise, what level of activity are they medically authorized for?
   ☐ Full ☐ Light Exercise ☐ No Exercise/ADL ☐ Other Limitations

5. Medical recommendations

6. Plan for follow-up and/or referral:

I certify that the patient above is medically stable for ongoing intensive outpatient care.

_____ _____

Signature Date

Address: Phone/Fax:

Please fax this report and requested tests to The Lotus Collaborative:

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