Portland DBT INSTITUTE

Re: Medical Clearance Report Required for Your Patient to Receive Outpatient Care

Dear Treatment Provider:

Your patient is considering receiving services at Portland DBT Institute (PDBTI), a full-fidelity DBT clinic serving a variety of people with serious behavioral problems. For patients with eating disorders and/or compromised nutritional status, we require a thorough medical examination by a qualified medical provider to determine whether the person is medically appropriate to receive outpatient care before treatment begins. Because eating disorders potentially affect every organ system, a comprehensive medical evaluation is required.

The purpose of this form is to ensure that your patient is medically stable to receive outpatient care. In addition, even after this determination, it is important that the patient receive continued medical monitoring and support from you on a weekly to monthly basis (as indicated by condition severity) throughout their course of treatment at PDBTI.

Specific requirements for the medical evaluation and a provider sign-off form are attached. We are very thankful for your time and the work you do for our community. If you have any questions about this form or would like any additional information, please do not hesitate to contact us at (971) 350-3350 or IOP@pdbti.org.

Sincerely,

Raquel Friedman, PsyD

Raquel Friedman, PsyD
Path to Mindful Eating IOP Manager

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Medical Evaluation

The medical exam should include:

1. A complete assessment of the client's general health including an EKG, orthostatic vitals, CBC with differential, CMP, thyroid panel, and B12 level.
2. Any medical concerns which are important to the client's care.
3. Activity protocol and any limitations on physical activities, if applicable.

Please attach copies of the following:

- ☐ EKG
- ☐ CBC with differential
- ☐ Thyroid panel
- ☐ CMP
- ☐ B12
- ☐ List of current medications
- ☐ List of current diagnoses
- ☐ Other (please specify):

Please provide the following details from the medical exam:

- Name of Patient:_____
- Date of Birth:_____
- Date of Exam:_____
- Sex:_____
- Height:_____
- Weight (blind weight unless requested by the patient):_____
- Blood pressure
  - Lying down:_____
  - Standing:_____
- Heart Rate
  - Lying down:_____
  - Standing:_____
- Respiratory rate:_____
- Temperature:_____
- Head/neck:_____
- Skin (lanugo, yellow palms and soles, jaundice, callus on fingers):_____
- Chest/lungs:_____
- Heart:_____
- Abdomen:_____
- GU (rectal/pelvic):_____
- Lymph system:_____
- Extremities:_____
- Neurological:_____
- EKG result interpretation:_____

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Provider Sign-off

Based on my evaluation, I have determined that the above-named patient is medically stable and appropriate for outpatient management. I have reviewed the requirements for admission to PDBTI, and based on my assessment this patient meets the admission requirements.

Physician or Advanced Practice Provider Name:_____

Signature:_____

Date:_____

Address:_____

Phone:_____

Fax:_____

Email:_____

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