branches
CENTER FOR COUNSELING & WELLNESS

41667 Ivy Street, Suite D
Murrieta, CA 92562
Office: 310-720-6443
Fax: 888-562-3648
www.branchescenter.com

Medical Clearance Form

Name: ____ DOB: _______________

The patient named above has applied for admission to our outpatient program for eating disorders. Patients must be medically stable to participate in outpatient therapy otherwise a higher level of care is necessary. Please examine the patient and complete the following certification. Please fax this form directly to the number above. Thank you.

Date of Exam: ____________________ ***Date of Most Recent Labs:*** __________________

Presenting Diagnosis			
Other Significant Medical Info/Injury			
Physical Exam	Height:	Weight:	Temp:
Orthostatic Measurements	Supine BP:	Standing BP:	
	Supine Pulse:	Standing Pulse:	
Medications/ Supplements			☐ none
Allergies Food & Medicine			☐ NKA

Additional comments or instructions regarding restrictions/recommendations to diet, exercise, work, other:

☐ There are no physical activity limitations

Next scheduled or recommended appointment ___________

Physician's name, address and phone (stamp is fine):

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I have examined this patient and certify that he/she is medically stable and able to participate in an outpatient eating disorder program at *Branches Center for Counseling & Wellness* and does not require further medical treatment that would impede participation.

____ ____________________

Physician Signature Date