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MEDICAL CLEARANCE FORM

Patient's Name: _____

Patient's DOB: _____

- ☐ Electrolytes analysis (including potassium, phosphorus and magnesium)
- ☐ Electrocardiogram
- ☐ Full vital signs(including orthostatics and temperature)
- ☐ Other analyses/exam (*please specify*) _____
- ☐ Additional comments/concerns: _____
  _____

☐ Based on the review of the aforementioned analyses and physical examination, I deem this patient medically stable to engage in outpatient treatment.
_____ (*please initial*)

OR

☐ Based on the results of the aforementioned analyses and physical examination, I find this patient in need of more constant medical monitoring, and thus will refer them to an inpatient treatment provider, where more extensive medical monitoring will be permissible. This patient is NOT medically stable to engage in outpatient treatment at this time.
_____ (*please initial*)

Signature of Physician: _____ **Date:** _____

Physician's Name: _____

Physician's Phone: _____ **Physician's Pager:** _____

Physician's Fax: _____ **Physician's Email:** _____

Physician's Mailing Address: _____