Patient Name: _____ DOB: _____ Exam Date: _____

Tapestry

Premier Program by Pyramid Healthcare

Please fax completed form to: (828) 654-0920
Phone: (828) 884-2475

Vitals

Sitting BP: _____ HR: _____
Standing BP: _____ HR: _____
Height: _____ Wt: _____
Last Menstrual Cycle: _____

ED Diagnosis

- ☐ Anorexia Nervosa - Restricting/ Binge/Purge
- ☐ Bulimia
- ☐ Binge Eating Disorder
- ☐ Other Specified Feeding/Eating D/O
- ☐ Other: _____

Mental Health History/Hospitalizations

_____
_____
_____
_____

Past/ Current Medical Conditions

_____
_____
_____
_____

Surgeries/Hospitalizations

_____
_____
_____

Communicable Diseases

Active TB Yes No
Other: _____

Allergies

Food: _____
Drug:_____
Other Dietary Restrictions:
_____

Current Eating Disorder Behaviors

(List Frequency/ Amount)

Bingeing: _____
Purging: _____
Type: Vomiting Laxative
Exercise: _____
Calorie Restriction: _____
Other: _____

Risk Assessment

Suicidal Ideation	Yes	No
Suicide Attempt	Yes	No
Self Harm	Yes	No
Violent Behavior	Yes	No

Labs – ALL ARE REQUIRED

***Results must be within 14 days PRIOR to admission date**

- ☐ CBC
- ☐ CMP
- ☐ EKG
- ☐ Phosphorus
- ☐ Magnesium
- ☐ HCG
- ☐ Urinalysis
- ☐ Hepatitis A, B, C screening
- ☐ TSH, free T3, free T4
- ☐ Pre-Albumin
- ☐ Vitamin D and Vitamin B12
- ☐ Urine Drug Screening
- ☐ PPD
- ☐ Documentation of any other pertinent history
- ☐ Growth Chart *(for pediatric clients only)*

Current Medications: (Name/Dose/Freq) Or attach list

_____
_____
_____
__

Patient Name: _____ DOB: _____ Exam Date: _____

Physical Exam

HEENT	☐ WNL	Other:
Dental	☐ WNL	Other:
Thyroid	☐ WNL	Other:
Chest/ Lungs	☐ WNL	Other:
Breast	☐ WNL	Other:
Heart	☐ WNL	Other:
Abdomen	☐ WNL	Other:
Pelvic	☐ WNL	Other:
Hair/Skin/Nails	☐ WNL	Other:
Musculoskeletal	☐ WNL	Other:
Neurological	☐ WNL	Other:
Extremities/Edema	☐ WNL	Other:

REQUIREMENTS FOR ADMISSION TO A RESIDENTIAL FACILITY

Is the patient ambulatory? Yes / No Details:
Can the patient manage her/his own medications? Yes / No Details:
Are there any limitations on physical activities? Yes / No Details:
Is the patient free from communicable diseases? Yes / No Details:

Are there additional assessments needed? Yes / No Details:
Are there any medical/psychiatric/medication instructions? Yes / No Details:

I hereby certify that _____is medically stable and meets all requirements for admission to a residential facility.

Physician Name: _____

Physician Signature: _____ Date: _____

Office Address: _____

Office Number: _____

Referral Contact: _____ Phone: _____

Patient Name: _____ DOB: _____ Exam Date: _____

RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____Date of Birth:_____

I authorize the use or disclosure of the above named individual's health information as described below. The information is to be disclosed by/ exchanged with:

Tapestry		NAME OF FACILITY:
11 N. Country Club Rd		ADDRESS:
Brevard, NC 28712	***AND***	CITY/STATE:
Phone: *828-884-2475*		PHONE #:
Fax: *828-654-0920*		FAX #:

The purpose or need for this disclosure is: (MARK ALL THAT APPLY)

- ✓ Tapestry Medical Form
- ✓ Labs results for last 3 months
- ✓ EKG results from last three months
- ✓ Growth Chart, if applicable
- ✓ Progress notes that relate to eating disorder/ mental health issues
- ✓ Current Medication List
- ✓ Last History and Physical
- ✓ Immunization Record
- ☐ Other: _____

I understand that this authorization will expire 365 days from the date it is signed unless I have specified a different expiration date or expiration event as follows: _____

I understand that I may cancel this authorization at any time by notifying in writing the Tapestry, 11 N Country Club Road, Brevard, NC 28712, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws. I understand that Tapestry will not condition treatment or eligibility for care on the provision of this authorization except if such care is: (1) research related or (2) provided for the sole purpose of creating Protected Health Information for disclosure to a third party.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____
Patient Signature Date

_____ _____
Parent or Legal Guardian Signature Date

_____ _____
Witness Name and Signature Date