Collaborating Medical Provider Attestation Form (pg 1)

*To be completed by medical provider

Your patient has requested to enter a therapeutic relationship with the team at Better Living Solutions Recovery Center (BLSRC) for the treatment of a feeding and/or eating disorder (ED). Per our accreditation with The Joint Commission, the patient needs to have a medical provider evaluate their physical health and be willing to collaborate on care during treatment. As such, we need your assistance with the following to proceed:

- **Collaborating Medical Provider Attestation Form** – ***BLSRC will schedule your patient's assessment when Page 2 is signed/returned. Please send below documents with form (when possible) or otherwise see bottom of Pg 2.***

- **Physical Exam Record Provided**

  - *Must be within the past year and include current prescribed medications/supplements (dosage and frequency). If the date of the exam exceeds one year, an updated exam is requested.*

  - ***If an adolescent**, additionally provide **Growth Charts** (when available). The Joint Commission, requests exams for adolescents include: motor development and functioning, Sensorimotor functioning, speech, hearing, and language functioning, visual functioning, immunization status, oral health and oral hygiene*

- **The Following Labs Ordered:**

  - Complete Blood Count (CBC)
  - Comprehensive Metabolic Panel (CMP)
  - Phosphorus
  - Magnesium
  - Thyroid Function Test
  - Hemoglobin A1c (*HbA1c only needed for binge eating or bulimia*)

  *Please note that labs must be **drawn within two weeks of assessment date**. Should labs not meet the two-week window, we may request a new lab order. Fasting is not required for our labs.*

- **Other Screenings for Consideration (not required):**

  - Electrocardiogram (**recommended**)
  - DEXA Scan
  - Urine Drug & Alcohol
  - HCG Pregnancy test (if applicable)

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Better Living
SOLUTIONS

Collaborating Medical Provider Attestation Form (pg 2)

*To be completed by medical provider

Client Identification

Name | Date of Birth | Age

Any known Medical Issues, Communicable Diseases, or Dietary Requirements that may impact/influence care of client (including allergies)?

Physician's Statement (Signature Required)

I agree to collaborate care with the clinical team at BLSRC on behalf of this patient and oversee their medical stability by requiring ongoing medical evaluations and laboratory testing as deemed appropriate and providing on-call services through my practice.

Attesting Physician's Name and Credentials, Address and Telephone Number (stamp acceptable)

Physician's Signature and Date below:

_____ ____/____/_____

For patients presenting with urgent counseling needs yet unable to obtain a PCP appt quickly, BLSRC will proceed with an ED assessment prior to the appt as long as PCP: 1) Signs this attestation form to collaborate with us on medical needs 2) Confirms patient has an upcoming appt scheduled and 3) Agrees to provide the medical documentation on pg 1 as soon as possible after the appointment.

If applicable, please complete this section and initial/date:

☐ New Patient Date of Upcoming Appt: _____

☐ Existing Patient Date of Upcoming Appt: _____ Date of Last Appt: _____

Initial/Date: _____

Should your patient disclose medical issues that need immediate attention during our assessment, BLSRC will notify your office and/or direct them to the Emergency Room if needed. Please do not delay returning this form so that we can identify and treat high-risk populations sooner. Thank you!

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