Eating Disorders Medical Unit Application

Application process

Upon receipt, your application will be reviewed for eligibility. Most applicants will have a screening interview with our psychologist prior to admission. If a bed is not immediately available, you will be placed on a waiting list. During this time we may request medical records and/or additional information, even if you have been in the Eating Disorders Medical Unit before.

Please note that **placement on the waiting list does not guarantee acceptance** and we reserve the right to limit admission to those who are most likely to benefit from the type of treatment we offer. If we are unable to accept you, we will provide you with a list of alternative programs which would be better suited to your situation.

Once accepted into the program you will be notified and may make an admission appointment.

Please complete all included documents. The checklist below has been provided to assist you.
When completed, fax application and insurance card to (310) 325-5732 or scan and email application and insurance card to application@drschack.com.

Patients under the age of 18 may have a parent or other adult complete the patient portion for them except where indicated.

- ☐ Patient information sheet *(to be completed by financially responsible party),* pages 2-3
- ☐ Patient treatment agreement (*to be completed by patient and parent),* page 4
- ☐ Communication preferences *(to be completed by patients over 18),* page 5
- ☐ Current treatment professionals, page 6
- ☐ Nutritional supplements *(to be completed by financially responsible party),* page 7
- ☐ Essay questions *(to be completed by patient),* page 8
- ☐ Treatment history, pages 9-11
- ☐ Copy of front and back of medical insurance card, page 12

IMPORTANT – Before returning, please double-check that you have filled out the admission packet as completely as possible, and have included a copy of the front and back of your insurance card. Incomplete information will delay the admission process.

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Patient information

Please print clearly.

Date: _____

Patient name: _____ Preferred pronouns: _____

Age: _____ Birthdate: _____

Marital status: _____ Patient's email (even if under 18): _____

Height: _____ Current weight: _____ Highest previous weight and date: _____

Occupation: _____ SSN#: _____

Home address: _____

City, State, ZIP code: _____

Patient's mobile phone (even if under 18): _____

Financially responsible party

Person financially responsible for cost of treatment.

☐ *If patient is responsible party, check this box and skip to Employment*

Responsible party name: _____ Birthdate: _____
Last *First* *Middle initial*

Email: _____ Relationship to patient: _____

Occupation: _____ SSN#: _____

Home address: _____

City, State, ZIP: _____

Home phone: _____ Mobile phone: _____

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Employment

Check one: ☐ *Patient or* ☐ *Responsible party*

Employer: _____ Job title: _____

Business address: _____

City, State, ZIP: _____

Significant other

Check one: ☐ *Second parent* ☐ *Spouse* ☐ *Domestic partner*

Name: _____ Email: _____

Birthdate: _____ Relationship to patient: _____

Occupation: _____ SSN#: _____

Home address: _____

City, State, ZIP: _____

Home phone: _____ Mobile phone: _____

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Patient treatment agreement

Patient to complete initial items 1-8.

I, _____ , agree to comply with all recommended treatment.
Patient's name

Specifically, I agree to:

1. Have a complete physical examination. *Patient's initials:* _____

2. Consume recommended food calories daily, by eating all presented meals or any portion of meals plus an amount of liquid supplement calorically equivalent to the uneaten portion. *Patient's initials:* _____

3. Take recommended medications. *Patient's initials:* _____

4. Allow laboratory testing as ordered. *Patient's initials:* _____

5. Participate in psychotherapy sessions. *Patient's initials:* _____

6. Comply with program requirements. *Patient's initials:* _____

7. Stay seated in a chair when not in bed (prolonged standing/walking around room is not permitted). *Patient's initials:* _____

8. I understand that unhealthy behaviors are not permitted, including cigarette smoking. *Patient's initials:* _____

Family member(s) to initial item 9.

9. Parent(s), caregiver(s), or significant other(s) agree to attend a minimum of two sessions of family education/support, once per week (can be done via phone/video conference if you are not local). *Family member(s) initials:* _____

_____ _____
Signature of patient (even if under 18) Date

_____ _____
Signature of parent or legal guardian if patient under 18 Date

Phone: 310-325-4353 • Fax: 310-325-5732 • application@drschack.com • edmu@tmmc.com

TorranceMemorial.org/EDMU

Linda Schack, MD • Lindsey Brucker, MD
Sarah Wohn, PsyD • Julia Baird, PsyD • Nicole Hayes, PhD • Michele Manarino, RD

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Communication preferences

All patients 18 and older must complete.

I, _____ , give permission for Linda Schack, MD, Lindsey Brucker, MD, Sarah Wohn, PsyD, Julia Baird, PsyD, Nicole Hayes, PhD, and Michele Manarino, RD, to communicate with the following people regarding the treatment of my eating disorder for the duration of my medical hospitalization (it is strongly recommended that both parents be listed if both are living and in contact with you).

Please list at least one parent or other adult close friend, partner or relative:

Name _____ Relationship _____

Phone: ☐ Home ☐ Mobile ☐ Work _____ Alternate phone: ☐ Home ☐ Mobile ☐ Work _____

Email _____

Name _____ Relationship _____

Phone: ☐ Home ☐ Mobile ☐ Work _____ Alternate phone: ☐ Home ☐ Mobile ☐ Work _____

Signature of patient _____ Date _____

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Current treatment professionals

To be completed by patient and/or parent.

Please list all health professionals involved in the treatment of your eating disorder within the past three years:

Primary care provider: _____

Phone: _____ Fax: _____

Primary therapist: _____

Phone: _____ Fax: _____

Primary dietitian: _____

Phone: _____ Fax: _____

Psychiatrist: _____

Phone: _____ Fax: _____

Other (family therapist, recovery coach, alternative medicine provider, etc.)

Name: _____ Specialty: _____

Phone: _____ Fax: _____

Referring program or institution (if applicable): _____

Clinical director: _____

Phone: _____ Fax: _____

I agree to the release of information between Linda Schack, MD, Lindsey Brucker, MD, Sarah Wohn, PsyD, Julia Baird, PsyD, Nicole Hayes, PhD, and Michele Manarino, RD, or their designees, and my previous treatment professionals.

Patient's signature: _____ Date: _____ Birthdate: _____

Parent's signature: _____ Date: _____

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Financial Information

Insurance

The hospital requires PPO insurance coverage.
Dr. Schack's billing is separate from the hospital's, so her office will bill your insurance company. If you receive a reimbursement check for Dr. Schack's portion of your hospitalization, we appreciate you promptly sending us a check for the same amount. Dr. Schack will accept this amount as payment in full for her services provided during your hospitalization.

Nutritional supplements
To be completed by financially responsible party.

Most patients who are admitted for medical stabilization related to an eating disorder benefit from nutritional supplementation. The choice of supplements is individualized; examples of frequently used supplements include calcium, potassium, magnesium, phosphorus, multivitamins, vitamin B12, B complex and probiotics (beneficial bacteria used to improve intestinal health).

Our hospital formulary is somewhat limited in this area. Therefore, our practice is to stock our own supplements and provide them when there is no equivalent hospital formulary product. We have most supplements on hand and can provide them to patients immediately. No sales tax is collected since physician-provided supplements are considered medical treatment.

Patients will be billed for supplements at the suggested retail price.

☐ I am providing my credit card information to cover the charges for recommended supplements. *Initials:* _____

☐ I am able to swallow vitamin-sized pills.

☐ I have difficulty swallowing vitamin-sized pills.

☐ Visa® ☐ Mastercard® ☐ Discover® ☐ American Express® Name on card: _____

Card number: _____ CVV: _____ Exp. date: _____

Billing address: _____

City, State, ZIP: _____

Signature: _____ Printed name: _____

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For the patient to complete.

Tell us a bit about yourself. Please answer the following questions as comprehensively as possible, so that we can best help you.

Why have you decided to seek help at this time?

What made you choose Torrance Memorial Medical Center's Medical Stabilization Program, as opposed to other treatment programs?

What are your goals for this hospital stay?

What are your current medical problems?

Patient's name: _____ Date: _____ Completed by: _____

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Treatment history

I have been in one or more intensive outpatient (IOP), partial hospital (PHP), residential, inpatient or medical stabilization programs.

☐ No *Please skip pages 9-10.*

☐ Yes *Please complete pages 9-10.*

Please list previous treatment programs, starting with the most recent (fill in as much information as you can).

1. Name of program/facility: _____

Type of program (check one): ☐ Psychiatric inpatient ☐ Medical stabilization ☐ Residential ☐ PHP ☐ IOP ☐ Other

Location (city/state): _____ Phone: _____

Primary therapist: _____

Clinical director: _____

Dates of treatment: _____ to _____

2. Name of program/facility: _____

Type of program (check one): ☐ Psychiatric inpatient ☐ Medical stabilization ☐ Residential ☐ PHP ☐ IOP ☐ Other

Location (city/state): _____ Phone: _____

Primary therapist: _____

Clinical director: _____

Dates of treatment: _____ to _____

3. Name of program/facility: _____

Type of program (check one): ☐ Psychiatric inpatient ☐ Medical stabilization ☐ Residential ☐ PHP ☐ IOP ☐ Other

Location (city/state): _____ Phone: _____

Primary therapist: _____

Clinical director: _____

Dates of treatment: _____ to _____

4. Name of program/facility: _____

Type of program (check one): ☐ Psychiatric inpatient ☐ Medical stabilization ☐ Residential ☐ PHP ☐ IOP ☐ Other

Location (city/state): _____ Phone: _____

Primary therapist: _____

Clinical director: _____

Dates of treatment: _____ to _____

5. Name of program/facility: _____

Type of program (check one): ☐ Psychiatric inpatient ☐ Medical stabilization ☐ Residential ☐ PHP ☐ IOP ☐ Other

Location (city/state): _____ Phone: _____

Primary therapist: _____

Clinical director: _____

Dates of treatment: _____ to _____

If more than five, list names of additional programs and year of treatment.

Program: _____ Year: _____

Program: _____ Year: _____

Program: _____ Year: _____

Program: _____ Year: _____

Program: _____ Year: _____

Program: _____ Year: _____

I, _____ , agree to the release of information between Linda Schack, MD, Lindsey Brucker, MD, Sarah Wohn, PsyD, Julia Baird, PsyD, Nicole Hayes, PhD, and Michele Manarino, RD, or their designees, and the above listed providers and their designees.

Signature: _____ Date: _____

Have you ever left a program against medical or professional advice?

☐ No

☐ Yes – name of program: _____

If yes, please describe what happened, and your reason for leaving.

Admission preference:

☐ As soon as possible, when a bed is available.

☐ Contingent upon travel plans/need lead time.

☐ Specific week requested: _____ (Admissions are generally scheduled in the mornings, Monday through Thursday.)

☐ Other: _____

Please attach a copy of the front and back of your insurance card.

_____ For office use _____

Disposition:

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