Torrance Memorial Medical Center
Eating Disorders Medical Unit

Phone (310) 325-4353 • Fax (310) 325-5732 • application@DrSchack.com
www.EatingDisordersAssociates.com
Linda Schack, MD • Lindsey Brucker, MD • Sarah Wohn, PsyD
Julia Baird, PsyD • Lauren Warren, LMFT • Michele Manarino, RD

In order to schedule your admission appointment, please complete all included documents. The checklist below has been provided to assist you.

When completed, fax to (310) 325-5732 or scan and email to application@DrSchack.com

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

Patient Information Sheet *(complete 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 Info *(complete 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 front and back of your <u>insurance card</u>. Incomplete information will delay the admission process.

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PATIENT INFORMATION

Please print clearly.

Date ___________________

Patient Name____

Age______Birthdate ______________Marital Status__________Patient's Email ___________________________

Height_____________ Current Weight_____________ Highest Previous Weight & Date_____________________

Occupation____SSN__________________________

Home address ____

City, State, Zipcode ____

Home Phone ______________________________Patient's Mobile Phone _______________________________

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 _____________________
Last *First* *Middle Initial*

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 and initial items 1-8.
*Family Member(s) to initial item 9. **
For patients under 18, parent to co-sign at bottom.

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 of 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. *Pt's Initials* _______
9. * Parent(s), caregivers, 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 *Date*

____ ________________________
Signature of parent or legal guardian if patient under 18 *Date*

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COMMUNICATION PREFERENCES

All patients 18 and older must complete.

I,___________________________________give permission for Lauren Warren, LMFT, and Doctors Schack, Brucker, Wohn and Baird 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*

____
Email

____ _______________________________
Name *Relationship*

_________________________________ _______________________________________
Phone ☐*Home* ☐*Mobile* ☐*Work* *Alternate phone* ☐*Home* ☐*Mobile* ☐*Work*

____
Email

____ __________________________
Signature of Patient *Date*

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CURRENT TREATMENT PROFESSIONALS

To be completed by patient and/or parent.

Referring Program or Institution (ifapplicable) ______________________________

Clinical Director ______________________________

Phone______________________________ Fax ______________________________

Please list all health professionals involved in the treatment of your eating disorder within the past 3 years:

Primary Care Physician______________________________

Phone______________________________Fax______________________________

Primary Therapist ______________________________

Phone______________________________Fax______________________________

Dietitian______________________________

Phone______________________________Fax______________________________

Psychiatrist ______________________________

Phone______________________________Fax______________________________

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

Name______________________________Specialty ______________________________

Phone______________________________Fax______________________________

I agree to the release of information between Doctors Brucker, Schack, Wohn, Baird, Lauren Warren LMFT, Michele Manarino RD, or their designees, and my previous treatment professionals.

Patient Signature______________________________Date______________Date of Birth______________

Parent 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. Her office bills 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 B-12, 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 ☐ MC ☐ Disc ☐ Amex Name on card____

Card #________________________________Security code__________Exp. date __________

Billing address ____

City, State Zip ____

Signature____________________________Printed name____________________________

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Tell us a bit about yourself. Please answer the following questions *as comprehensively as possible*, so that we can best help you.
(for the patient to complete)

Why have you decided to seek help at this time?

____

____

____

____

What made you choose TMMC Medical Stabilization Program, as opposed to other treatment programs?

____

____

____

____

What are your goals for this hospital stay?

____

____

____

____

What are your current medical problems?

____

____

____

Signed__________________________ Relationship to Patient_________________________ Date______________

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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 this page.

Yes Please complete this page.

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: (circle) Psychiatric Inpatient, Medical Stabilization, Residential, PHP, IOP, or other

   Location – City/State____________________ Phone______________

   Primary Therapist______________________________

   Clinical Director______________________________

   Dates of Treatment______________to______________

2. Name of Program/Facility______________________________

   Type of Program: (circle) Psychiatric Inpatient, Medical Stabilization, Residential, PHP, IOP, or other

   Location – City/State____________________ Phone______________

   Primary Therapist______________________________

   Clinical Director______________________________

   Dates of Treatment______________to______________

3. Name of Program/Facility______________________________

   Type of Program: (circle) Psychiatric Inpatient, Medical Stabilization, Residential, PHP, IOP, or other

   Location – City/State____________________ Phone______________

   Primary Therapist______________________________

   Clinical Director______________________________

   Dates of Treatment______________to______________

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4. Name of Program/Facility____

   Type of Program: (circle) Psychiatric Inpatient, Medical Stabilization, Residential, PHP, IOP, or other

   Location – City/State____________________________________ Phone__________________

   Primary Therapist____

   Clinical Director____

   Dates of Treatment________________to________________

5. Name of Program/Facility____

   Type of Program: (circle) Psychiatric Inpatient, Medical Stabilization, Residential, PHP, IOP, or other

   Location – City/State____________________________________ Phone__________________

   Primary Therapist____

   Clinical Director____

   Dates of Treatment________________to________________

If more than 5, 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 Doctors Brucker, Schack, Wohn, Baird, Lauren Warren LMFT, Michele Manarino RD, or their designees, and the above listed providers and their designees.

Signature____________________________________ Date__________________

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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 copy of front and back of your insurance card.

____For Office Use____

Disposition: