

Medical Clearance & Permission Form

For the Healthy Futures Intensive Outpatient Program (IOP)
To Be Signed By Patient's Primary Care Physician

*Please complete the information below

_____ Date of most recent office visit
_____ Date of most recent labs, if done
_____ normal or _____ abnormal (what levels) _____
**If abnormal, how is it being treated? _____
_____ Date of most recent EKG, if done

I _____ (Dr./PA/NP name)

_____ **Do** certify that _____ (patient name) is in good medical standing to participate in an intensive outpatient program one to four days per week, three hours each day and does not require further medical treatment that would preclude participation (tube feeding, rehydration, I. V.'s to balance electrolytes, etc.)

_____ **Do not** certify that _____ (patient name) is in good medical standing to participate in an intensive outpatient program one to four days per week, three hours each day for the following reason: _____

Any restrictions/suggestions that you would recommend (diet, exercise, work, additional treatment, medical interventions, etc.)?

I am available to consult with if needed at _____ (phone #).

I plan on following this patient on a regular basis as needed. YES NO

Signature

Date

Print Name

Practice Address & Phone: _____

Please fax to: Healthy Futures at (480) 451-8510
For further questions/information: **Mia S. Elwood, LCSW (program director)**
480-451-8500
HealthyFuturesAZ@cox.net
www.HealthyFuturesAZ.com