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