Practice Logo

Practice Address

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**Informed Consent for Health, Wellness, and Lifestyle Coaching**

I, the undersigned, requested and have consented to participate in a health, wellness, and lifestyle coaching program and format, offered by the wellness/health coach designated by the office of Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. The lifestyle program known as Launch Your Healthy Life is hereafter known as the Program.

I understand that the coaching, education, and mentoring afforded myself, will involve advice in the areas of food, diet, nutrition, exercise, sleep quality, stress management, and vitamins and supplements. Furthermore, it is understood that there is no claim that any specific lifestyle changes will serve as therapy, treatment, or remedy for any specific disease. I understand that adopting any of these recommendations is voluntary and by my choice.

I fully understand that all lifestyle recommendations, including but not limited to physical exercise, food and nutrition, stress management, and sleep quality are designed with my health, well-being and utmost safety in mind.

I agree to seek the advice of my physician or another qualified health care professional prior to and during the Program regarding any questions or concerns I have about my specific health situation, possible or actual pregnancy, known or suspected food sensitivities or allergies, dietary restrictions, or any medications I am currently taking. It is understood that lifestyle changes may alter requirements for medication dosing. I agree to not disregard professional medical advice or delay seeking professional advice or stop taking any medications without speaking to my physician or health care professional.

Any information that is obtained from my medical history, fitness level, and coaching sessions will be treated as privileged and confidential and will not be released or revealed to any person other than my healthcare providers without my expressed written consent.

In the event that I may injure myself or become ill as a result of my participation in this program and my election to make voluntary lifestyle changes, I hereby release, discharge, and waive any and all liability, damages, causes of action, allegations, suits, sums of money, claims and demands which I have ever had, now have, and could have in the future arising from my participation in anything related to the Program, now or in the future.

I understand the value of being compliant to lifestyle change recommendations, when physically and emotionally possible, and agree to participate in group or individual session appointments in a timely and punctual manor. It is understood that ‘no-show’ or last minute cancellations may result in no refunds, and in extreme circumstances of non-participation; cancellation of the coaching agreement. A 24-hour cancellation notice is requested.

The financial aspects of participating in the Program, and the time commitments, have been disclosed and accepted.

I further understand that most patients respond in a positive manor in the 12 week format dedicated to the Program delivery. In the event my preexisting health conditions prove to challenge the normal timeline, I understand that the wellness coach and myself can mutually agree to add additional coaching sessions at an additional hourly session rate.

**Signature:** electronic or physical**,** verifies I have read and agree to the above terms and conditions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Date

**Lifestyle Risk Management Assessment Questionnaire page 1**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list your four major health concerns in order of importance:**

Office Notes:

1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please describe your objectives and/or expected outcomes from participating in a lifestyle re-set program.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please answer the following questions in each category

Office Notes:

Medical HX Risk

\_\_\_\_ low

\_\_\_\_ mod

\_\_\_\_high

**Medical History** – [X = yes]

\_\_\_\_ Have two or more chronic diseases ongoing now

\_\_\_\_ Heart attack or stroke? \_\_\_\_ High blood pressure

\_\_\_\_ Diabetic? \_\_\_\_ Pre-diabetic

\_\_\_\_ Any autoimmune disease? \_\_\_\_ Arthritis

\_\_\_\_ COPD \_\_\_\_Cancer

\_\_\_\_ Bowel disorder/ IBS/Crohn’s \_\_\_\_ Gum disease

\_\_\_\_Chronic fatigue \_\_\_\_ Depression

\_\_\_\_ Pregnant \_\_\_\_ Past miscarriage

\_\_\_\_ Describe other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Genetic History** –[X= yes]

\_\_\_\_ Parent had heart disease/ stroke \_\_\_\_ Parent had cancer

Office Notes:

Genetic HX Risk

\_\_\_\_low

\_\_\_\_mod

\_\_\_\_high

\_\_\_\_Grandparent had heart disease/stroke \_\_\_\_ Grandparent had cancer

\_\_\_\_ Sibling had/has heart disease/stroke \_\_\_\_ Sibling had/has cancer

\_\_\_\_ Parent dementia \_\_\_\_ Parent depression

\_\_\_\_ Grandparent dementia \_\_\_\_ Grandparent depression

\_\_\_\_ Sibling dementia \_\_\_\_ Sibling depression

**Medication Review –** [X= yes] In last 60 days have you taken:

\_\_\_\_Antacids \_\_\_\_Antianxiety med \_\_\_\_Antibiotics

\_\_\_\_Anticonvulsant \_\_\_\_Antidepressant \_\_\_\_Antifungal

\_\_\_\_Aspirin/Ibuprofen \_\_\_\_Beta blocker \_\_\_\_Birth control

\_\_\_\_Chemotherapy \_\_\_\_Cholesterol Lowering \_\_\_\_Corticosteroid

\_\_\_\_Diabetic meds \_\_\_\_Diuretic \_\_\_\_ HRT

\_\_\_\_Heart med/any \_\_\_\_High blood pressure \_\_\_\_Laxatives

\_\_\_\_Recreational drug \_\_\_\_Relaxants/sleeping aids \_\_\_\_Thyroid med

\_\_\_\_Tylenol \_\_\_\_Ulcer med \_\_\_\_ED med

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lifestyle Risk Management Assessment Questionnaire page 2 of 3**

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**General Lifestyle Review – [X = yes]**

\_\_\_\_ Exercise 0 – 2 X weekly/20 min \_\_\_\_Exercise 3 - 4 X weekly/20 mins \_\_\_\_Exercise 5 or more/20 mins

\_\_\_\_Fast food 0 -2 X weekly \_\_\_\_Fast food 3- 4 X weekly \_\_\_\_Fast Food 5 plus X weekly

\_\_\_\_Do not try to restrict sugar \_\_\_\_Somewhat restrict sugar \_\_\_\_Restrict sugar always

\_\_\_\_Do not try to restrict oils \_\_\_\_Somewhat restrict seed oils \_\_\_\_Do not use seed oils

\_\_\_\_Do not restrict trans fats \_\_\_\_Somewhat restrict trans fats \_\_\_\_Avoid trans fats

\_\_\_\_Do not eat balanced meals \_\_\_\_Sometimes eat balanced meals \_\_\_\_Always eat balanced

\_\_\_\_Drink 2 – 4 glasses of Water daily \_\_\_\_Drink 5-8 glasses of water daily \_\_\_\_Drink 9 – 12 glasses

\_\_\_\_Drink 3 – 5 beers/drinks weekly \_\_\_\_Drink 5 – 10 beers/drinks weekly \_\_\_\_Drink more than 10 weekly

\_\_\_\_Do not smoke \_\_\_\_Do not use recreational drugs

\_\_\_\_Feel stress frequently \_\_\_\_Occasionally feel stress \_\_\_\_Never feel stressed

\_\_\_\_Have few stable relationships \_\_\_\_Have just enough stable relationships \_\_\_\_Have many

\_\_\_\_Do not feel balanced in life \_\_\_\_Sometimes feel balanced \_\_\_\_Always feel balanced

\_\_\_\_Do not sleep well in general \_\_\_\_Sleep well mostly \_\_\_\_Sleep well always

\_\_\_\_ Am not a happy person \_\_\_\_ Am somewhat happy \_\_\_\_Am mostly always happy

\_\_\_\_Am gluten free \_\_\_\_Am a vegetarian/vegan \_\_\_\_Am a carnivore

**Gastrointestinal review –** [X=yes]

\_\_\_\_Frequent stomach cramps/discomfort \_\_\_\_Frequent bloating, gas \_\_\_\_ Frequent diarrhea

\_\_\_\_Frequent constipation \_\_\_\_ Feeling of fullness after meals \_\_\_\_Bad breath

\_\_\_\_Acid reflux \_\_\_\_Sleepy after meals \_\_\_\_Frequent back pain

\_\_\_\_Dry skin \_\_\_\_Hormone balance difficulty \_\_\_\_Brain fog

\_\_\_\_Black tarry stool \_\_\_\_Gallbladder pain \_\_\_\_History H pylori

\_\_\_\_History ulcers \_\_\_\_History candida/yeast \_\_\_\_Always feel hungry

\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Body aches and pain- joints and muscles-** [X = yes]

**\_\_\_\_** General joint pain **\_\_\_\_** General muscular pain \_\_\_\_ Restless leg syndrome

\_\_\_\_ Swollen joints **\_\_\_\_** Carpel tunnel discomfort \_\_\_\_Frequent leg cramps

\_\_\_\_ Frequent back pain no injury \_\_\_\_ Back pain history of injury \_\_\_\_ Neck pain, no injury

\_\_\_\_ Neck pain history of injury \_\_\_\_TMJ discomfort/pain \_\_\_\_Foot pain

\_\_\_\_Headaches/ migraines \_\_\_\_Headaches frequent \_\_\_\_Headaches occasionally

\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nervous system- emotional wellness review –** [X=yes]

\_\_\_\_Manage stress well \_\_\_\_Sometimes manages stress well \_\_\_\_Do not manage stress well

\_\_\_\_Never feel depressed \_\_\_\_Sometimes feel depressed \_\_\_\_Treated for depression

\_\_\_\_Never feel anxious \_\_\_\_Sometimes feel anxious \_\_\_\_ Treated for anxiety

\_\_\_\_Easy to fatigue \_\_\_\_Difficult to concentrate \_\_\_\_Worry a lot

\_\_\_\_Breathe through nose day \_\_\_\_Breathe through nose night \_\_\_\_Snore at night/grind teeth

\_\_\_\_Sleep well \_\_\_\_ Sleep OK mostly \_\_\_\_Do not sleep well

\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Autoimmune and skin wellness review-** {X=yes]

\_\_\_\_Frequent skin rash/hives \_\_\_\_ Eczema \_\_\_\_Psoriasis

\_\_\_\_Frequent cold sores \_\_\_\_Frequent oral herpes \_\_\_\_Food allergies

\_\_\_\_Airborne allergies \_\_\_\_Frequent sinus congestion \_\_\_\_Gluten sensitivity

\_\_\_\_Lectin sensitivity \_\_\_\_Dairy sensitivity \_\_\_\_Frequent candida

\_\_\_\_Antibiotic allergies \_\_\_\_Peanut allergy \_\_\_\_Insect allergies

\_\_\_\_Cracks in corners of mouth \_\_\_\_Frequent diarrhea \_\_\_\_ Arthritic tendencies

\_\_\_\_Ulcer and colitis tendencies \_\_\_\_Taking a steroid now \_\_\_\_Diagnosed with immune disease

\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lifestyle Risk Management Assessment Questionnaire page 3 of 3**

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**Cardiovascular wellness review-** [X=yes]

\_\_\_\_Feel heart racing \_\_\_\_Have daytime incidents of sweating for no reason \_\_\_\_No stamina

\_\_\_\_Hard to walk up stairs \_\_\_\_Frequent headaches \_\_\_\_Sleep apnea

\_\_\_\_Take heart meds \_\_\_\_Have had stents/bypass surgery \_\_\_\_HBP

\_\_\_\_Swollen ankles \_\_\_\_ Purple color under eyes \_\_\_\_Chest pressure

\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Metabolic wellness review-** {X=yes]

\_\_\_\_Difficult to loose weight \_\_\_\_Easy to gain weight \_\_\_\_Have tried many diets

\_\_\_\_Always hungry \_\_\_\_Crave sugar/chocolate \_\_\_\_Dry mouth

\_\_\_\_Frequent urination \_\_\_\_Lack of energy/tired a lot \_\_\_\_Frequent thirst

\_\_\_\_Cuts heal slowly \_\_\_\_Gums bleed easily \_\_\_\_Binge eating/crave food

\_\_\_\_Eat too much sugar \_\_\_\_Borderline diabetic \_\_\_\_Treated for diabetes

\_\_\_\_Don’t know if I am diabetic \_\_\_\_Tend to snack before bedtime \_\_\_\_Overweight now

\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Oxygenation, airway, sleep quality review-** {X=yes]

\_\_\_\_Existing lung disease \_\_\_\_Frequent bouts of pneumonia \_\_\_\_Frequent allergies

\_\_\_\_Sleep poorly /restless \_\_\_\_ Snore/grind teeth at night \_\_\_\_Breath through mouth

\_\_\_\_Feel fatigued during day \_\_\_\_Have gum disease/treated for \_\_\_\_ 6 to 7 hours of sleep

\_\_\_\_Yawn a lot during day \_\_\_\_Easy to dose while driving \_\_\_\_Difficult falling asleep

\_\_\_\_Sleep with 2 or more pillows \_\_\_\_Use a C-PAP unit at night \_\_\_\_Diagnosed lung disease

\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hormone review –**

In your own words, describe how or if you are managing any of the following hormone categories:

Thyroid \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insulin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Estrogen \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Progesterone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Testosterone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vitamins and supplements –** List those you take on a regular basis with dosage amount

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Thank You

Practice Logo

Practice Address

Practice Phone

Practice email contact

**Patient Lifestyle Coaching: Referral for Medical Consult**

Dear Doctor/Medical Provider:

RE: Patient Name DOB Date of referral

The patient seeks lifestyle changes in the areas of diet and nutrition, exercise, stress management, and sleep quality, and has agreed to wellness coaching by one of our team members. As a result of changing and improving lifestyle choices, many times medication dosages can change, and hormone balances will be altered.

The patient has been advised to let the primary care provider[s] be aware of potential adjustments in their supervised systemic heath markers. In addition, please share any support or concerns you may have or foresee.

Our concerns for this patient’s overall systemic health are in the following areas:

\_\_\_\_Metabolic health \_\_\_Cardiovascular \_\_\_Diabetic \_\_\_ Gastrointestinal

\_\_\_\_Cognitive \_\_\_Other

We look forward to future mutual collaboration to optimize patient wellness and health.

Thank you for the kind consideration,

Name

Signature

Practice Logo

Practice Address

Practice Phone

Practice email contact

**Patient Referral for Medical Consult and Collaboration**

Dear Doctor/Medical Provider:

RE: Patient Name DOB Date of referral

As a result of ongoing periodontal disease and the high likelihood of translocating pathogens, and/or ongoing concurrent chronic diseases, and/or the systemic immune compromise that is inherent, it is our opinion the patient requires additional medical supervision and potential testing.

The following testing has been done through our office:

\_\_\_\_Periodontal pathogen test \_\_\_\_A1C/Blood glucose \_\_\_\_hsCRP \_\_\_\_Other

Our concerns for this patient’s overall systemic health are in the following areas:

\_\_\_\_Metabolic health \_\_\_Cardiovascular \_\_\_Diabetic \_\_\_ Gastrointestinal

\_\_\_\_Cognitive \_\_\_ Other

Please consider additional testing in appropriate areas to validate any shared concerns. Our office promotes and educates lifestyle changes that will impact the negative aspects that systemic inflammation and oxidative stress have on all chronic disease.

We look forward to future mutual collaboration to optimize patient wellness and health.

Thank you for the kind consideration,

Name

Signature