BioIntelligent Wellness

PHYSICIAN RELEASE TO PARTICIPATE

RE: Ideal Protein Weight Loss Method

Patient Name: _____
Patient Date of Birth: _____

Dear Physician:

The above named mutual patient is requesting to start the Ideal Protein Weight Loss Management Program which is monitored weekly in our office. We would like to have your medical clearance for him/her to start. Please fax your clearance responses on the next page to 760-994-1248. Alternately, you may also email it to info@biointelligentwellness.com.

The Ideal Protein Weight Loss Method consists of a four phase medically-designed protocol. This protocol was developed 25 years ago and has been successful with over 7 million dieters and is currently recommended by more than 3,000 health professionals across North America. The first two phases focus on weight loss and also stabilization of blood sugar levels, blood pressure and other obesity related issues. The second two phases help the dieter stabilize and maintain their weight loss and health achievements.

This is not a high protein diet, it is a hypo-caloric low fat, low carbohydrate and adequate protein diet. The patient will use a combination of their foods and Ideal Protein foods. The protein isolate rich foods are non-GMO and have a very high biological value, are low in calories, low in fat and contain eight essential amino acids.

Feel free to call us anytime regarding this patient or this program. We have informed the patient that you, as their prescribing physician, will be monitoring pertinent vitals and medication(s)/dosage changes. They are aware that if medication dosage changes must be made, they will be made entirely by you. As progress occurs, we will encourage this patient to follow up with you regularly while on this program.

Sincerely,

Julianna Nikolic, B.S.
Integrative Clinical Nutritionist & Founder

THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN GIVING MEDICAL CLEARANCE.

Patient Name: _____

Will you monitor patient's medications throughout weight loss program: YES / NO

Potential Risk Level: LOW / MODERATE

Current medications prescribed by your office for this patient:
_____ for condition: _____
_____ for condition: _____
_____ for condition: _____
_____ for condition: _____

Comments: _____
_____

Physician Signature: _____ Date: _____

Physician Name Printed: _____

Please fax to 760-994-1248.

Thank you!