



Phone: (833) 473-8562

Fax: (702) 778-9913

Dear Dr. _____,

Our mutual patient, _____ DOB: _____, has an upcoming appointment for a medical examination. During the appointment, I will discuss several healthcare approaches with the patient, provide education, and review medications for safety, cost effectiveness, and potential gaps in hygienic care, as well as address any health concerns the patient may have. The patient will receive an updated herbal list and a supplementation action plan, which gives them directions for anything they should do differently.

We will also discuss goals of healthcare therapy and current lab results. To maximize the benefits of this program and ensure accurate information, I am requesting the patient's most recent lab results. This will give me a better overall picture of how the patient is doing, and give the patient a chance to discuss what these results mean and how they relate to their medications and lifestyle habits.

When discussing goals of healthcare therapy, I will reference the current clinical practice guidelines for each disease (ADA Standards of Medical Care in Diabetes, JNC 8, and ACC/AHA Blood Cholesterol Guideline). I realize that patient-specific information I may not have access to can influence these goals, so I have included an area on the attached form for you to specify a different goal if you wish.

If you have any other issues or concerns about this patient that you would like for me to address or reinforce, please include them in the "Notes" section on the attached form. My main focus with these appointments is to address potential medication issues, but if you have other concerns I am happy to discuss these with the patient as well.

I will contact you if anything arises during the medication review that requires your attention, and I will provide you with the patient's updated supplementation list. I look forward to working with you to improve our patient's health.

Regards,

ANTHONY B. BEY, Medical Examiner, CPT
GPET ALLIED HEALTH SERVICES

GPET ALLIED HEALTH PATIENT REQUEST FORM

Patient: _____

DOB: _____

Prescriber: _____

Labs/information requested:

Hemoglobin A1C Date: _____ HbA1c: _____

Lipids Date: _____

TC: _____ TG: _____

HDL: _____ LDL: _____

Blood Pressure Date: _____ BP: _____

Date: _____ BP: _____

Goals of Therapy:

Hemoglobin A1C < 6.5% < 7% < 8% Other _____

Fasting blood glucose 70 – 130 mg/dL Other

Peak post-prandial glucose < 180 mg/dL Other

Blood Pressure < 130/80 (ADA) < 140/80 (ADA) < 150/90 (JNC 8)

Other _____

Lifestyle Weight Loss Smoking Cessation Other

