Working Together on Behalf of Our Patient

Date: _____

To:_____ of _____

From: _____

Re: _____

Dear Dr._____:

This is a medical opinion request on behalf of our client who is seeking therapy services for pain management. As part of her program, we are prescribing supplements to support her ability to participate in therapy and improve her condition. Currently our client's activities of daily living are limited for these reasons:

- Joint and muscular pain in bilateral arms, legs, and knees
- Pain in lower back and neck
- Inflammation of joints
- Numbness in the left foot with generalized weakness
- Symptoms are chronic and range from 2/10 at rest and 8/10 with activity (10 = worst pain)
- Worse in the morning and with activity

The client is currently taking the following prescribed medications:

- Furosemide, potassium Chloride, Synthroid, Combigan, Cyanocobalamin, Latanoprost, Pilocarpine, PreserVision

Based on her medical history, evaluation, assessment, and findings, we believe she would benefit from the isotonix form of the following supplements as part of the treatment plan:

- Nutrametrix Joint Support: Addresses joint stiffness and pain
- Nutrametrix OPC 3: An antioxidant for inflammation and recovery after physical rehabilitation
- Nutrametrix Magnesium: For symptoms of nerve pain

***Note**: We have attached detailed information and studies supporting the benefits and safety of these recommended supplements.*

Based on your treatment history with our client, knowledge of the patient's medical history, and the additional information we have provided, we request your opinion on the attached form.

Treatment Duration:

- We are requiring or client to adhere to the supplement protocol for 120 days.

Summary:

It is physically necessary this patient receive the recommended supplements as part of her therapy plan of care. The supplements are necessary to facilitate recovery and tolerance of therapeutic activities necessary to reach the client's goal of living with reduced pain and increased function of her person.

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Dear Doctor:

By signing below, you are not held liable for any final decisions made by our client regarding the plan of care with WholePerson Therapeutics nor their decision to proceed with accepting the recommended supplements as part of their care plan. Through educating the client both holistically and medically, we prevent further decline in function and increase clients' awareness and safety during participation in daily activities. Please respond to the following questions:

To the best of your knowledge, would any ingredient in the **Joint Support supplements** (see attached) have an aversive interaction with client's current medication or diagnosis? ☐ **Yes** ☐ **No**

a. If Yes:
   i. Which supplement: _____
   ii. Which ingredient: _____
   iii. What effect: _____
   iv. Recommended non-pharmaceutical alternative: _____

2. To the best of your knowledge, would any ingredients in the **Nutrametrix OPC 3 supplement** have an aversive interaction with client's current medication or condition? ☐ **Yes** ☐ **No**
   a. If Yes:
      i. Which supplement: _____
      ii. Which ingredient: _____
      iii. What effect:_____
      iv. Recommended non-pharmaceutical alternative: _____

3. To the best of your knowledge, would any ingredients in the **Nutrametrix OPC 3 supplement** have an aversive interaction with client's current medication or condition? ☐ Yes ☐ No
   a. If Yes:
      i. Which supplement: _____
      ii. Which ingredient: _____
      iii. What effect:_____
      iv. Recommended non-pharmaceutical alternative: _____

Physician/Health Provider Name (PRINT):_____

Provider Office: _____

Provider Signature: _____