INTEGRATIVE MEDICINE
& WELLNESS CENTER

TREATMENT PLAN

Patient Name_____ DOB_____

Address_____ Date_____

The following medications and/or supplements are an integral part of your BHRT therapy and may be purchased in our office. For refills, set up auto ship (applies to most products), or call and we will mail them to you or stop by the clinic during business hours.

SUPPLEMENTS

Unless specified, these supplements can be taken anytime of day without regards to meals.

_____ Active Probiotic #60 ☐ 1 per day ☐ 2 per day

_____ ADK #60 ☐ 1 per day ☐ 2 per day *(Take with fatty food such as egg, dairy, etc.)*

_____ ADK10 #90 ☐ 1 per day ☐ 2 per day

_____ B12 (Methylcobalamin) ☐ Spray - Daily ☐ Injections - Weekly (Slim Shot / Super B)

_____ B Complex #90 ☐ 1 per day ☐ 2 per day

_____ DIM #60 or #90 ☐ 1 per day ☐ 2 per day ☐ 3 per day

_____ HRT Complete E #60 ☐ 1 per day ☐ 2 per day

_____ HRT Complete T #60 ☐ 1 per day ☐ 2 per day

_____ Iodine #90 ☐ 1 per day ☐ 2 per day ☐ Start in 2 weeks

To prevent potential detox symptoms (e.g. headache, fatigue), <u>ALSO take</u>:

- ✓ 2000 – 4000 mg Vitamin C: *daily*
- ✓ B-complex: *daily*
- ✓ ½ tsp Celtic or Mediterranean sea salt in warm water; *drink daily for 2 weeks*

_____ Iron Bis-Glycinate #60 ☐ 1 per day ☐ 2 per day for _____ days then decrease to 1 per day

_____Omega Plus #60 ☐ 1 per day ☐ 2 per day

_____Other:_____ ☐ 1 per day ☐ 2 per day ☐ _____

PRESCRIPTIONS

_____ Desiccated thyroid:_____mg every morning. This should be taken on an empty stomach. Please wait 45-60 minutes before putting anything else on your stomach. This includes coffee, food, medications, vitamins or supplements.

_____ *Wean off Synthroid/levothyroxine/Armour: Alternate your desiccated thyroid every other day with Synthroid/levothyroxine/Armour for three (3) weeks then go to every day on your desiccated thyroid.*

_____Progesterone, *compounded, micronized* ☐ 100mg ☐ 200mg **EVERY** night

_____Other:_____

_____ Wean off your antidepressant (*Wean Protocol Provided)*.

INSTRUCTIONS

_____BHRT Pellet Post Insertion Instructions reviewed and provided.

_____ Additional Instructions below reviewed and provided.

_____

_____

Do not stop prescriptions or recommended supplements without advising your practitioner.

I acknowledge that I understand all information and instructions and that a copy has been provided.

Patient Name	**DOB**	**Signature**	**Date**