

Medical Provider Request for Blood Lab Testing

Patient Name: _____ Date of Birth: _____

To the Patient: Please bring this Request for Blood Lab Testing to your medical provider to complete the basic lab testing panel we are recommending for you. If you are looking to have these lab tests billed to your insurance it is your responsibility (as the patient) to confirm that you have insurance coverage for lab testing, and to know what your health insurance deductible or co-pays may be when the medical lab bills your insurance for this testing. **Please make sure you authorize the medical facility to have these lab results sent to our clinic ASAP.**

To the Medical Provider: We are requesting that you support this patient in their goal of taking more responsibility for their health, and in being more proactive in preventing future health problems. The information we learn from the recommended lab tests below will allow us to provide expert guidance to this patient for any dietary, lifestyle or nutritional therapies that would be of greatest benefit for improving any current health conditions, and preventing health issues later in life. This patient looks forward to complimenting your expert medical care with the natural healthcare options we offer to our patients. Thank you for your supporting this patient in their journey for better health!

We are suspicious of this patients health status due to:

- | | | | |
|---|--------------------------------------|--|---|
| <input type="checkbox"/> Disturbed Sleep | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Decreased Energy | <input type="checkbox"/> Weight Issues |
| <input type="checkbox"/> General Malaise | <input type="checkbox"/> Headaches | <input type="checkbox"/> Skin Issues | <input type="checkbox"/> Blood Pressure Issues |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Digestive Disturbances |
| <input type="checkbox"/> Eye / Vision Issues | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Irritable / Moody | <input type="checkbox"/> Tingling / Numbness in |
| <input type="checkbox"/> Joint Pain / Muscle Pain | <input type="checkbox"/> Other: | | <input type="checkbox"/> Extremities |

Recommended lab testing:

- All of the lab test items listed below
- Only the circled items listed below

Glucose, Serum	A/G Ratio	TSH
Hemoglobin A1c	Bilirubin, Total	T3 Uptake
Uric Acid, Serum	Alkaline Phosphatase	Free T3
BUN	LDH	Free T4
Creatinine, Serum	AST (SGOT)	Reverse T3
eGFR	ALT (SGPT)	TPO Antibody
BUN/Creatinine Ratio	GGT	Thyroglobulin Antibody
Sodium, Serum	Iron Bind Cap (TIBC)	Vitamin D, 25-Hydroxy
Potassium, Serum	Iron, Serum	Fibrinogen Activity
Chloride, Serum	Iron Saturation	ESR (Sed. Rate)
Carbon Dioxide, Total	Ferritin, Serum	CBC with Differential
Calcium, Serum	Cholesterol, Total	Urinalysis
Phosphorus, Serum	Triglycerides	
Magnesium, Serum	HDL Cholesterol	
Protein, Total, Serum	LDL Cholesterol	
Albumin, Serum	C-Reactive Protein, Cardiac	
Globulin, Serum	Homocysteine, Plasma	

This request for Blood Lab Testing is provided by:

Signature: _____ Date: _____

Rachael KraMer; Holistic Health Practitioner

Skekinah Wellness
13875 Evergreen St NW
Andover, MN 55304
Phone: 763-923-8112
Fax: 763-785-9446