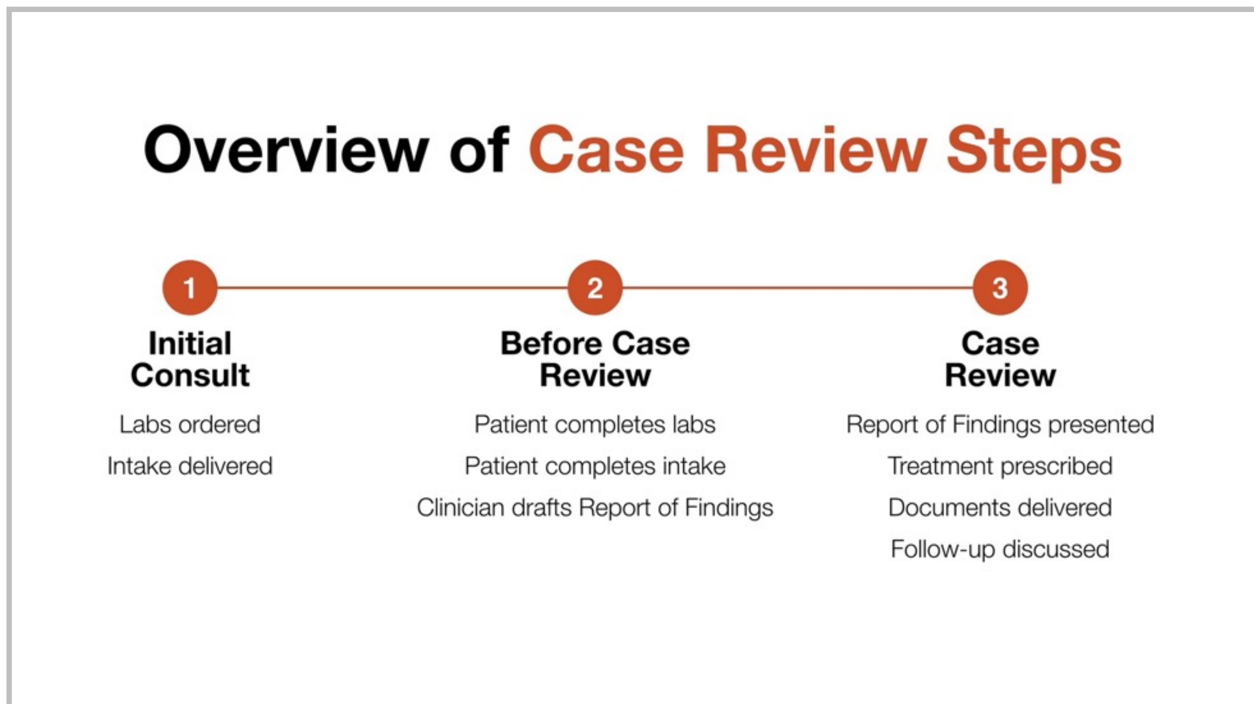
PM Case Review — Part 1

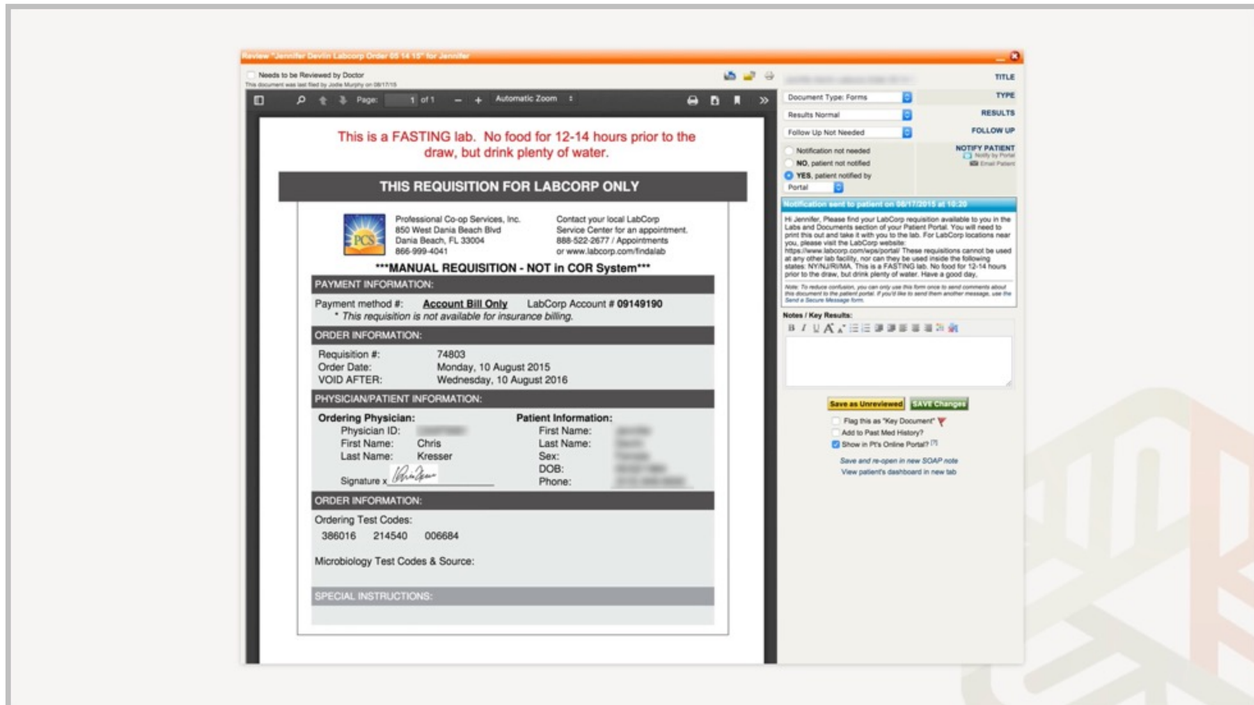
Hey everyone, in this presentation we're going to go into a lot more detail about the case review appointment. We'll start with what happens before the appointment occurs, with the new patient intake and Report of Findings, and then we'll discuss how to structure the appointment, how to set expectations for treatment, and how to follow up after the case review appointment.

As you'll recall from earlier sections, the case review appointment is a 60- to 75-minute in-person meeting where you present the Report of Findings to the patient. My case reviews are 60 minutes, currently. Dr. Nett's are 75 minutes; she prefers slightly longer case review appointments because she does a physical exam and because she's a little newer to the process. I started with 60 minutes and I've stuck with that. This largely comes down to your own personal preference. In the Report of Findings, you cover the underlying patterns that are causing your patient's conditions and symptoms, recommendations for further testing, and then you review the treatment plan. So put simply, in the case review appointment, you tell the patient why they're sick and how you're going to treat them. You also set expectations for how long a treatment will take and what they can expect in rough outlines.



So, here I've outlined the timeline and overview of steps involved in the case review process. During the initial consult, you collect their chief complaints and then you order the appropriate labs based on those complaints. In the follow-up from that appointment, the patient also receives instructions on how to complete the intake paperwork, which is part of the case review, and the deadline for doing that, which should be at least 48 hours or preferably more prior to the case

review appointment, so you and your staff have time to get the forms ready and you have time to review them. Then before the case review appointment, I do this on the morning of the case review, but you can do it a day before or earlier if you prefer, you review the patient labs and all of the patient intake paperwork, and then you create the Report of Findings. At the case review appointment, you meet the patient; you present the Report of Findings; you order the necessary treatment, whether that's supplements or medications if you prescribe medication; you deliver the support handouts and documents; you deliver the Report of Findings; you provide access to the lab slips, the lab orders or the lab kits; and you discuss the follow-up, when the patient should schedule their first follow-up appointment. So let's talk about the key elements of this process in more detail.


Needs to be Reviewed by Doctor

This is a FASTING lab. No food for 12-14 hours prior to the draw, but drink plenty of water.

THIS REQUISITION FOR LABCORP ONLY

Professional Co-op Services, Inc.
850 West Dania Beach Blvd
Dania Beach, FL 33004
866-999-4041

Contact your local LabCorp Service Center for an appointment.
888-522-2677 / Appointments
or www.labcorp.com/findalab

MANUAL REQUISITION - NOT in COR System

PAYMENT INFORMATION:

Payment method #: **Account Bill Only** LabCorp Account # **09149190**
* *This requisition is not available for insurance billing.*

ORDER INFORMATION:

Requisition #: 74803
Order Date: Monday, 10 August 2015
VOID AFTER: Wednesday, 10 August 2016

PHYSICIAN/PATIENT INFORMATION:

Ordering Physician:
Physician ID:
First Name: Chris
Last Name: Kresser
Signature x

Patient Information:
First Name:
Last Name:
Sex:
DOB:
Phone:

ORDER INFORMATION:

Ordering Test Codes:
386016 214540 006684

Microbiology Test Codes & Source:

SPECIAL INSTRUCTIONS:

After the initial consult, you'll order the necessary labs for the patient, as we've already discussed, and deliver the intake forms that the health history questionnaires, etc., that they need to fill out through the patient portal. I'm providing working procedures that describe in a step-by-step fashion how to do this for your staff. For blood work requisitions, those are delivered via the patient portal, as you can see here on this slide, this is an example. And for kits like stool or breath or urine testing, the instructions are delivered via the portal, and the kits are drop-shipped, typically directly from the lab.

We also link patients to FAQ documents for each lab, and I'm providing these for you as well. They're hugely important, and they've cut down significantly on patient questions. The labs really can be quite overwhelming, they're a lot to coordinate, and you should tell patients to look at these FAQs and directions right after the initial consult, plan ahead, and even ask the staff if they have

any questions, because this will help prevent any delay of them getting the labs done before the case review appointment.

Metabolic Assessment Form [x]

Please list the 5 major health concerns in your order of importance

-
-
-
-
-

Please check the appropriate number on all questions below. 0 as least/never to 3 as most/always.

Category I	0	1	2	3
Feeling that bowels do not empty completely				
Lower abdominal pain relieved by passing stool or gas				
Alternating constipation and diarrhea				
Diarrhea				
Constipation				
Hard, dry, or small stool				
Coated tongue or "fuzzy" debris on tongue				
Pass large amount of foul-smelling gas				
More than 3 bowel movements daily				
Use laxatives frequently				

Category II	0	1	2	3
Excessive belching, burping, or bloating				
Gas immediately following a meal				
Offensive breath				
Difficult bowel movement				
Sense of fullness during and after meals				
Difficulty digesting fruits and vegetables; undigested food found in stools				

Category III	0	1	2	3
Stomach pain, burning, or aching 1-4 hours after eating				
Use antacids				
Feel hungry an hour or two after eating				
Heartburn when lying down or bending forward				
Temporary relief by using antacids, food, milk, or carbonated beverages				
Digestive problems subside with rest and relaxation				
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine				

Category IV	0	1	2	3
Roughage and fiber cause constipation				
Indigestion and fullness last 2-4 hours after eating				
Pain, tenderness, soreness on left side under rib cage				
Excessive passage of gas				
Nausea and/or vomiting				
Stool undigested, foul smelling, mucous like, greasy, or poorly formed				
Frequent urination				
Increased thirst and appetite				

Category V	0	1	2	3
Greasy or high-fat foods cause distress				
Lower bowel gas and/or bloating several hours after eating				
Bitter metallic taste in mouth, especially in the morning				
Burpy, fishy taste after consuming fish oils				
Difficulty losing weight				
Unexplained itchy skin				
Yellowish cast to eyes				
Stool color alternates from clay colored to normal brown				
Reddened skin, especially palms				
Dry or flaky skin and/or hair				
History of gallbladder attacks or stones				
Have you had your gallbladder removed?	Yes		No	

Category VI	0	1	2	3
Acne and unhealthy skin				
Excessive hair loss				
Overall sense of bloating				
Bodily swelling for no reason				
Hormone imbalances				
Weight gain				
Poor bowel function				
Excessively foul-smelling sweat				

Category VII	0	1	2	3
Crave sweets during the day				
Irritable if meals are missed				
Depend on coffee to keep going/get started				
Get light-headed if meals are missed				
Eating relieves fatigue				
Feel shaky, jittery, or have tremors				
Agitated, easily upset, nervous				
Poor memory/forgetful				
Blurred vision				

Category VIII	0	1	2	3
Fatigue after meals				
Crave sweets during the day				
Eating sweets does not relieve cravings for sugar				
Must have sweets after meals				
Waist girth is equal or larger than hip girth				
Frequent urination				
Increased thirst and appetite				
Difficulty losing weight				

The new patient intake forms are also filled out in the portal. These are actually built into MD HQ, so as the patient fills them out, they will automatically appear for you in MD HQ. If you choose to use MD HQ, we're looking at ways that they can make these forms available to you along with some of the other customizations that we've done, so we'll let you know about that. Once a patient completes the forms, I have my staff combine them into a single document that's easy for me to review as I prepare the Report of Findings. If you use another EHR or different kind of system, I've provided these forms for you as Microsoft Word or PDF documents, so you can either prep them electronically within your own EHR's requirements, or you can deliver them electronically as Word documents, or paper, or however you want to do it. What you see here on the slide is adapted from the metabolic assessment, adapted and expanded from that. It's based on a questionnaire that was originally designed by Apex Energetics, which is a supplement company that also offers some training in functional medicine. It's a good survey of symptoms organized by a body system or category. For example, category I is mostly symptoms that would be related to colon health; number II and number III are reflux, GERD, hypochlorhydria symptoms; number IV is small intestine; number V is gallbladder; number VI is liver function; number VII is low blood sugar; and number VIII is high blood sugar.

Category IX	0	1	2	3
Cannot stay asleep				
Crave salt				
Slow starter in the morning				
Afternoon fatigue				
Dizziness when standing up quickly				
Afternoon headaches				
Headaches with exertion or stress				
Weak nails				
Category X	**0**	**1**	**2**	**3**
Cannot fall asleep				
Perspire easily				
Under high amount of stress				
Weight gain when under stress				
Wake up tired even after 6 or more hours of sleep				
Excessive perspiration or perspiration with little or no activity				
Category XI	**0**	**1**	**2**	**3**
Edema and swelling in ankles and wrists				
Muscle cramping				
Poor muscle endurance				
Frequent urination				
Frequent thirst				
Crave salt				
Abnormal sweating from minimal activity				
Alteration in bowel regularity				
Inability to hold breath for long periods				
Shallow, rapid breathing				
Category XII	**0**	**1**	**2**	**3**
Tired/sluggish				
Feel cold—hands, feet, all over				
Require excessive amounts of sleep to function properly				
Increase in weight even with low calorie diet				
Gain weight easily				
Difficult, infrequent bowel movements				
Depression/lack of motivation				
Morning headaches that wear off as the day progresses				
Outer third of eyebrow thins				
Thinning of hair on scalp, face, or genitals, or excessive hair loss				
Dryness of skin and/or scalp				
Mental sluggishness				
Category XIII	**0**	**1**	**2**	**3**
Heart palpitations				
Inward trembling				
Increased pulse even at rest				
Nervous and emotional				
Insomnia				
Night sweats				
Difficulty gaining weight				

Category XIV	0	1	2	3
Diminished sex drive				
Menstrual disorders or lack of menstruation				
Increased ability to eat sugars without symptoms				
Category XV	**0**	**1**	**2**	**3**
Increased sex drive				
Tolerance to sugars reduced				
"Splitting" - type headaches				
Category XVI *(Males Only)*	**0**	**1**	**2**	**3**
Urination difficulty or dribbling				
Frequent urination				
Pain inside of legs or heels				
Feeling of incomplete bowel emptying				
Leg twitching at night				
Category XVII *(Males Only)*	**0**	**1**	**2**	**3**
Decreased libido				
Decreased number of spontaneous morning erections				
Decreased fullness of erections				
Difficulty maintaining morning erections				
Spells of mental fatigue				
Inability to concentrate				
Episodes of depression				
Muscle soreness				
Decreased physical stamina				
Unexplained weight gain				
Increase in fat distribution around chest and hips				
Sweating attacks				
More emotional than in the past				
Category XVIII *(Menstruating Females Only)*	**0**	**1**	**2**	**3**
Perimenopausal	Yes		No	
Alternating menstrual cycle lengths	Yes		No	
Extended menstrual cycle (greater than 32 days)	Yes		No	
Shortened menstrual cycle (less than 24 days)	Yes		No	
Pain and cramping during periods				
Scanty blood flow				
Heavy blood flow				
Breast pain and swelling during menses				
Pelvic pain during menses				
Irritable and depressed during menses				
Acne				
Facial hair growth				
Hair loss/thinning				

Numbers IX and X are HPA axis dysregulation; number XI is cardiovascular system or heart; number XII is hypothyroid; number XIII is hyperthyroid; number XIV is pituitary hypofunction; number XV is pituitary hyperfunction; number XVI is male reproductive health, prostate issues; number XVII is other male reproductive issues like andropause; number XVIII is hormonal issues for menstruating females.

Category XIX *(Menopausal Females Only)*	0	1	2	3
How many years have you been menopausal?	years			
Since menopause, do you ever have uterine bleeding	Yes		No	
Hot flashes				
Mental fogginess				
Disinterest in sex				
Mood swings				
Depression				
Painful intercourse				
Shrinking breasts				
Facial hair growth				
Acne				
Increased vaginal pain, dryness, or itching				

How many alcoholic beverages do you consume per week?
How many caffeinated beverages do you consume per day?
How many times do you eat out per week?
How many times a week do you eat raw nuts or seeds?
How many times a week do you eat fish?
How many times a week do you workout?
List the three worst foods you eat during the average week:
List the three healthiest foods you eat during the average week:
Do you smoke? Yes | No
Do you currently have mercury amalgams (fillings) Yes | No
Have you had mercury amalgam fillings removed in the past? Yes | No
Rate your levels of stress on a scale of 1-10 during the average week: [Select]
Please list any medications you currently take and for what conditions:
Please list any natural supplements you currently take and for what conditions:
SUBMIT THIS ASSESSMENT

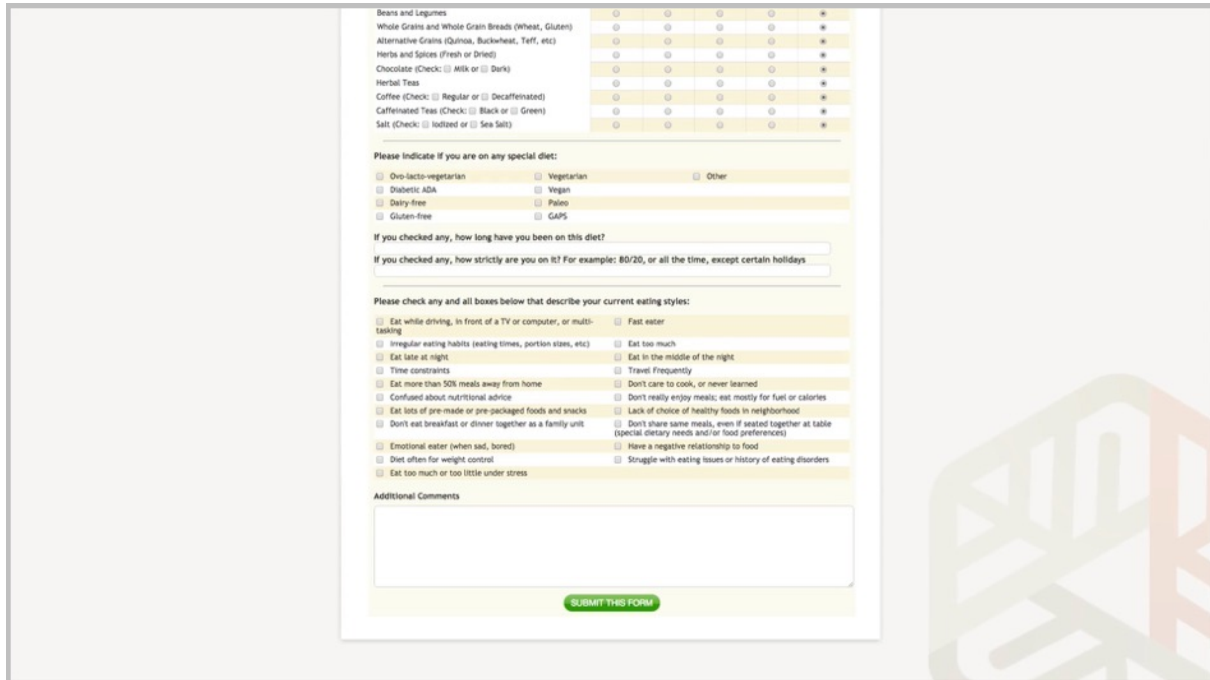
Number XIX is symptoms that might be experienced by menopausal females. So these are only signs and guidelines, you can't make a diagnosis from this; for example, if someone has a high score in a category that refers to high blood sugar, you can't diagnose them with high blood sugar based only on that, but it can give you some ideas for where to look more carefully, and that's really what it's designed for. So after all of that, I have questions about their dietary habits, whether they smoke cigarettes, their exposure to mercury, and medications and supplements.

Food Survey [x]

Indicate the frequency with which you eat the following foods by marking in the appropriate box. **FREQUENT**= at least once a day, **OFTEN**= several times per week, **OCCASIONAL**= once a week or less, **SELDOM**= once or twice a month or less, **NEVER**= total avoidance.

	Frequent	Often	Occas.	Seldom	Never
Alcoholic Beverages	○	○	○	○	●
Eat Out at Restaurants	○	○	○	○	●
Pastries, Cookies, Candy, Ice Cream and Other Sweets	○	○	○	○	●
White Flour: Bread, Pasta, Pancakes, Crackers, Muffins, etc	○	○	○	○	●
Add Sugar to Coffee, Tea, Cereals, or Other Foods	○	○	○	○	●
Sodas or Soft Drinks	○	○	○	○	●
Diet Soft Drinks	○	○	○	○	●
Fruit Juices	○	○	○	○	●
Artificial Sweeteners (NutraSweet, Saccharin, etc)	○	○	○	○	●
Natural Sweeteners (Honey, Maple Syrup, Agave, etc)	○	○	○	○	●
Breakfast Cereals (Hot or Cold)	○	○	○	○	●
Packaged Foods:Chips, Crackers, Puffs, Pretzels	○	○	○	○	●
Vegetable Oils (Sunflower, Safflower, Canola, Corn, Soy)	○	○	○	○	●
Margarine or Tub Vegetable Oil Spreads	○	○	○	○	●
Deep-Fried Foods	○	○	○	○	●
Olive Oil	○	○	○	○	●
Avocados	○	○	○	○	●
Saturated Fats (Butter, Ghee, Lard, Coconut, Palm, Tallow)	○	○	○	○	●
Fatty Fish (Salmon, Mackerel, Sardines, Herring)	○	○	○	○	●
Nuts and Seeds, Nut/Seed Butters	○	○	○	○	●
Pasteurized Dairy (Check: ☐ Nonfat, ☐ Low-Fat, ☐ Whole)	○	○	○	○	●
Raw Dairy Products (Check: ☐ Nonfat, ☐ Low-Fat, ☐ Whole)	○	○	○	○	●
Fermented Dairy Products (Yogurt, Kefir, Cheese)	○	○	○	○	●
Eggs (Check: ☐ Free-Range, ☐ Pastured, ☐ Organic, or ☐ Conventional)	○	○	○	○	●
Poultry or Fowl (Chicken, Turkey, Duck, etc)	○	○	○	○	●
Pork	○	○	○	○	●
Red Meat (Beef, Lamb)	○	○	○	○	●
Processed Meats (Bacon, Sausage, Salami, Ham, etc)	○	○	○	○	●
Organ Meats (Liver, Kidney, Sweetbreads, etc)	○	○	○	○	●
Soy Products (Tofu, Tempeh, Soy Milk, Edamame)	○	○	○	○	●
Salads, Uncooked Vegetables	○	○	○	○	●
Fermented Vegetables (Sauerkraut, Kim Chi, etc)	○	○	○	○	●
Non-Starchy Vegetables (Greens, Squash, Carrots)	○	○	○	○	●
Starchy Vegetables (Potatoes, Yams, Sweet Potatoes)	○	○	○	○	●
Fresh Fruits	○	○	○	○	●

The next is a very detailed dietary survey. So we ask them how frequently they eat these foods or consume these beverages and alcohol; how often they eat out at restaurants, pastries, cookies, candies, etc.; white flour; how often they add sugar to food; how often they consume vegetable oils; how often they consume more nutrient-dense foods like fatty fish, nuts and seeds, eggs, meat, etc. So it's a really helpful way of just getting an at-a-glance idea of what patients are eating.



Beans and Legumes
Whole Grains and Whole Grain Breads (Wheat, Gluten)
Alternative Grains (Quinoa, Buckwheat, Teff, etc)
Herbs and Spices (Fresh or Dried)
Chocolate (Check: Milk or Dark)
Herbal Teas
Coffee (Check: Regular or Decaffeinated)
Caffeinated Teas (Check: Black or Green)
Salt (Check: Iodized or Sea Salt)

Please indicate if you are on any special diet:

- Ovo-lacto-vegetarian
- Vegetarian
- Other
- Diabetic ADA
- Vegan
- Dairy-free
- Paleo
- Gluten-free
- GAPS

If you checked any, how long have you been on this diet?

If you checked any, how strictly are you on it? For example: 80/20, or all the time, except certain holidays

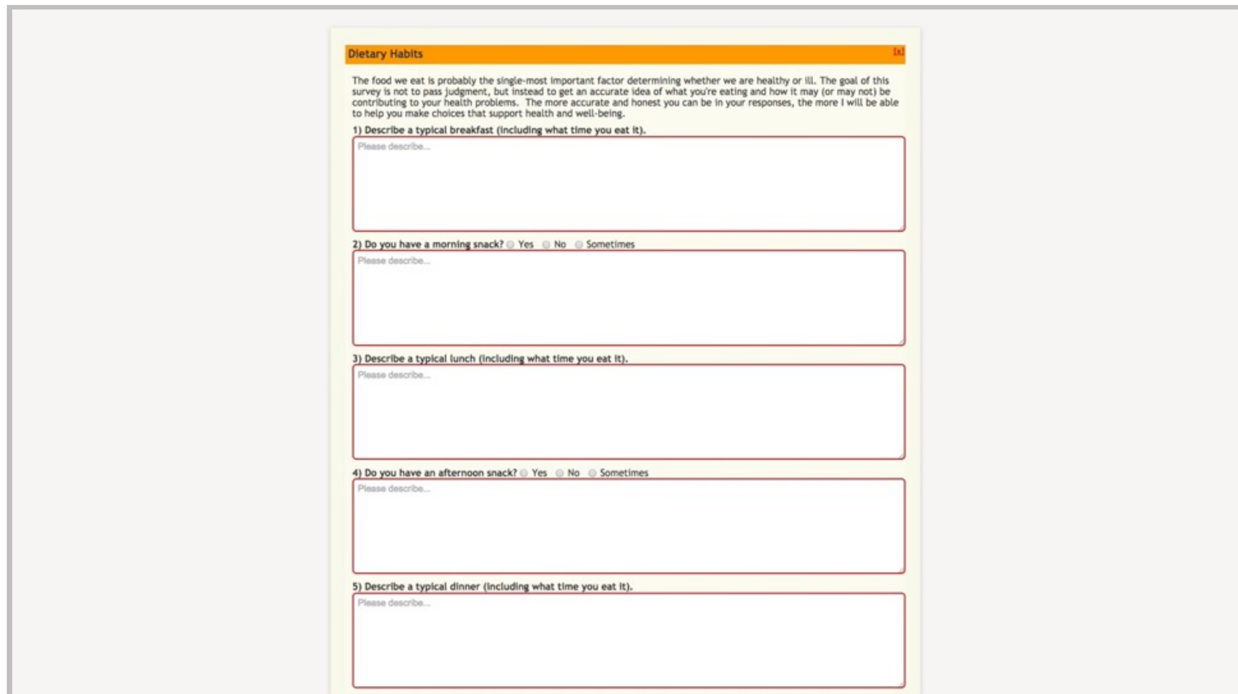
Please check any and all boxes below that describe your current eating styles:

- Eat while driving, in front of a TV or computer, or multi-tasking
- Fast eater
- Irregular eating habits (eating times, portion sizes, etc)
- Eat too much
- Eat late at night
- Eat in the middle of the night
- Time constraints
- Travel Frequently
- Eat more than 50% meals away from home
- Don't care to cook, or never learned
- Confused about nutritional advice
- Don't really enjoy meals; eat mostly for fuel or calories
- Eat lots of pre-made or pre-packaged foods and snacks
- Lack of choice of healthy foods in neighborhood
- Don't eat breakfast or dinner together as a family unit
- Don't share same meals, even if seated together at table (special dietary needs and/or food preferences)
- Emotional eater (when sad, bored)
- Have a negative relationship to food
- Diet often for weight control
- Struggle with eating issues or history of eating disorders
- Eat too much or too little under stress

Additional Comments

SUBMIT THIS FORM

Then I ask them to indicate if they're on a special diet—Paleo, GAPS, vegetarian, etc. I ask them to share any particular dietary habits or current eating styles, so do they eat late at night, do they eat while they're driving, in front of a TV or computer, and this can be really helpful because what we eat, of course, is important, but how we eat is also very important and can give you a lot of clues as to what's happening with a patient in terms of stress.



Dietary Habits [x]

The food we eat is probably the single-most important factor determining whether we are healthy or ill. The goal of this survey is not to pass judgment, but instead to get an accurate idea of what you're eating and how it may (or may not) be contributing to your health problems. The more accurate and honest you can be in your responses, the more I will be able to help you make choices that support health and well-being.

1) Describe a typical breakfast (including what time you eat it).
Please describe...

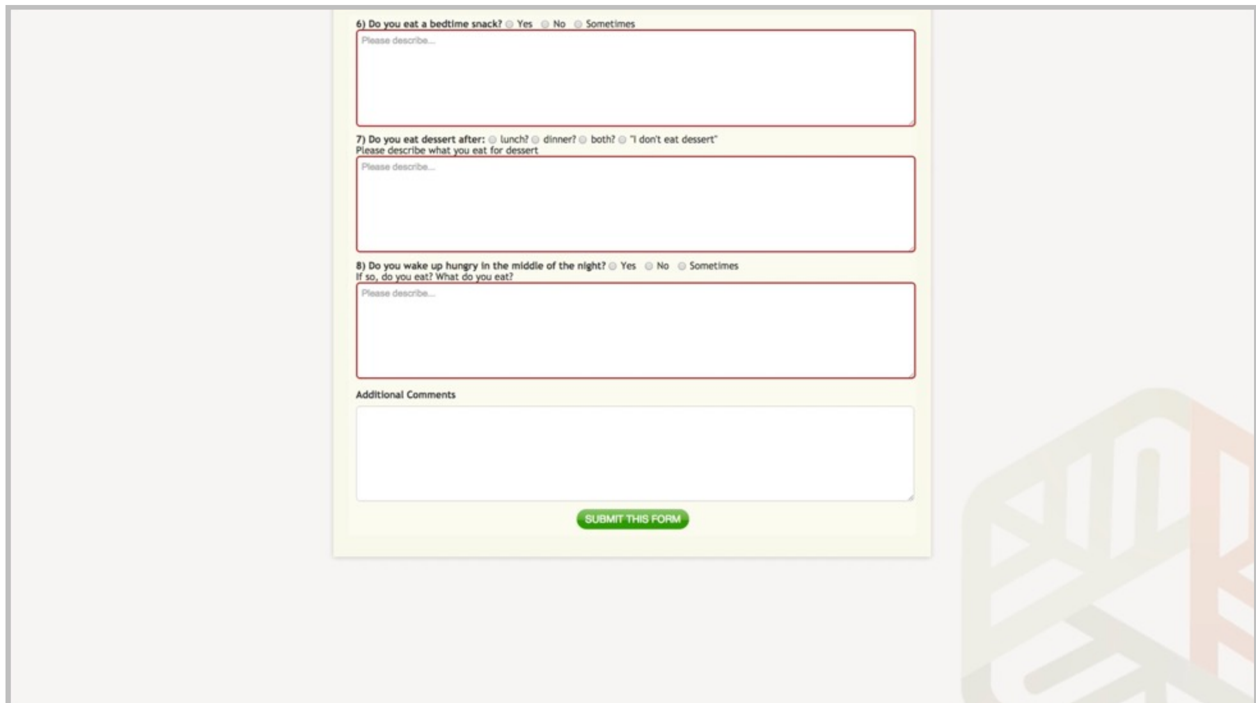
2) Do you have a morning snack? Yes No Sometimes
Please describe...

3) Describe a typical lunch (including what time you eat it).
Please describe...

4) Do you have an afternoon snack? Yes No Sometimes
Please describe...

5) Describe a typical dinner (including what time you eat it).
Please describe...

But beyond that, I also ask patients to give me a kind of day in the life of their diet, and I find this to be more enlightening than any other part of the food survey. You'll typically learn a lot from just seeing what a patient eats for their typical breakfast, the morning snack, typical lunch, afternoon snack, typical dinner. I have a little blurb at the top, just saying this isn't about judging them, it's about getting clear information about what they're eating so we can help and make appropriate recommendations, and I've found that most patients are really honest about this because they want help and they want me to be able to comment on what they're doing so that they can make improvements.



6) Do you eat a bedtime snack? Yes No Sometimes

Please describe...

7) Do you eat dessert after: lunch? dinner? both? "I don't eat dessert"
Please describe what you eat for dessert

Please describe...

8) Do you wake up hungry in the middle of the night? Yes No Sometimes
If so, do you eat? What do you eat?

Please describe...

Additional Comments

SUBMIT THIS FORM

This is the last part of the diet survey. I ask if they're eating bedtime snacks, do they eat dessert, and are they waking up hungry in the middle of the night.