



**Matthew C. Kirkham, D.C., C.C.S.P.**  
*Clinic Director, Certified Chiropractic Sports Physician*  
**Dale V. Applegate, D.C.**  
*Clinic Founder*

2504 Monroe Street  
LaPorte, IN 46350  
Phone: (219) 326-5100  
Fax: (219) 326-0180

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

**RE: Ideal Protein Weight Loss Method**

Dear Physician:

The above named mutual patient is requesting to start the Ideal Protein Weight Loss Management Program which is monitored weekly in our office. We would like to have your medical clearance for him/her to start. Feel free to call me anytime regarding this patient or this program. This patient has been informed by me that any medication monitoring or dosage changes must be made entirely by you as the prescribing physician. I will send you updates as progress occurs and encourage this patient to follow up with you regularly. **Please fax your clearance response along with any instructions to 219-326-0180.**

The Ideal Protein Weight Loss Method consists of a four phase medically-designed protocol – weight loss in the first two phases and weight maintenance in the later two. **The program has a beginning and an end.** High quality protein isolate rich foods are offered which have a very high biological value, are low in calories, low in fat and contain eight essential amino acids. This is **NOT** a hyper-protein diet! Our protocol not only ensures weight loss, but also stabilization of blood sugar levels and other obesity related issues. This protocol was developed 25 years ago, has been successful with over 7 million dieters and is currently recommended by more than 3,000 health professionals across North America.

Sincerely,

Matthew C. Kirkham, D.C., C.C.S.P.

**THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN GIVING MEDICAL CLEARANCE:**

Patient Name: \_\_\_\_\_

Will you monitor patient's medications throughout weight loss program? **YES / NO**

Potential Risk Level: **LOW / MODERATE / HIGH**

Current medications prescribed by your office for this patient:

1. \_\_\_\_\_ for condition: \_\_\_\_\_
2. \_\_\_\_\_ for condition: \_\_\_\_\_
3. \_\_\_\_\_ for condition: \_\_\_\_\_
4. \_\_\_\_\_ for condition: \_\_\_\_\_

Comments: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name Printed: \_\_\_\_\_ Phone: \_\_\_\_\_