Functional Protocol & Informed Consent Worksheet

Client Name: _____ Date: ___ Practitioner: _____ *Protocol Phase:* __

Section 1: Proposed Functional Protocol

Note: The following recommendations are intended to support physiological structure and function. They are not intended to diagnose, treat, cure, or prevent any disease.

Intervention (Supplement/Lifestyle)	Clinical Intent (e.g., "Supports healthy sleep")	Frequency/Duration
1.		
2.		
3.		
4.		

Section 2: Financial Transparency & Ethical Testing

In alignment with ethical guidelines, the following represents the estimated out-of-pocket investment for this phase of your wellness journey.

- **Estimated Functional Lab Fees:** $____
- **Estimated Monthly Nutraceutical Cost:** $____
- **Clinical Utility:** This testing/protocol is recommended because: _____

Section 3: Risk Management & Collaborative Care

To ensure your safety and maintain the professional "Standard of Care," please complete the following checkboxes:

- [ ] **PCP Notification:** I acknowledge that I have been advised to inform my Primary Care Physician (PCP) about these functional recommendations, especially regarding herbal supplements and their potential interactions with current medications.
- [ ] **Standard of Care Disclosure:** I understand that these functional interventions may be considered "off-label" or "investigational" and may not be recognized as the conventional "Standard of Care" by traditional medical boards.

- [ ] **Red Flag Awareness:** I have been briefed on "Red Flag" symptoms (e.g., sudden chest pain, severe allergic reaction) that require immediate cessation of the protocol and a visit to an Urgent Care or Emergency Room.

Section 4: Client Understanding & Reflection

On a scale of 1-10, how confident do you feel in implementing this protocol? __

Questions or concerns regarding the cost or nature of these recommendations:

Dual-Signature Informed Consent

Practitioner Statement: I have explained the nature, potential benefits, and known risks of this functional protocol. I have verified that these recommendations fall within my professional Scope of Practice.

Practitioner Signature: _____ Date: ___

Client Statement: I have read the above protocol and financial disclosures. I understand that my practitioner is not a substitute for a licensed medical doctor (unless otherwise specified) and that I am choosing to engage in this functional wellness plan voluntarily.

Client Signature: _____ *Date:* _____

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