

FOLATE DEFICIENCY CHECKLIST

Provider Name: _____

Provider Phone #: _____

Patient Name: _____

Patient DOB: _____

Patient Phone #: _____

CHECKLIST OF CONTRIBUTORS TO FOLATE DEFICIENCY:

1. FAMILY HISTORY THAT SUGGESTS MTHFR POLYMORPHISM (AN INHERITED GENETIC MARKER FOR DEPRESSION)

IF TWO (2) OR MORE BOXES ARE CHECKED, MTHFR IS SUSPECTED

- Mental Illness:** Depression, Anxiety, OCD, PTSD, ADHD
- Addiction or Addictive Behavior:** Drugs, Alcohol, Smoking, Eating, Gambling, Shopping etc.
- Diabetes**
- Miscarriages or Birth Defects**
- Cardiovascular Issues** – Any Heart Disease

2. CONDITIONS

- | | |
|--|--|
| <input type="checkbox"/> Malabsorption Syndromes | <input type="checkbox"/> Canker Sores |
| <input type="checkbox"/> Digestive Tract Disease | <input type="checkbox"/> History of Alcohol/Drug Abuse |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Anemias |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Poor Nutrition |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Breast Feeding |

3. DRUGS

- | | |
|--|---|
| <input type="checkbox"/> Lamictal | <input type="checkbox"/> Anticonvulsants |
| <input type="checkbox"/> Metformin | <input type="checkbox"/> Oral Contraceptives |
| <input type="checkbox"/> Methotrexate | <input type="checkbox"/> Cholesterol Lowering |
| <input type="checkbox"/> Corticosteroids | <input type="checkbox"/> Diuretics |
| <input type="checkbox"/> NSAIDs | <input type="checkbox"/> H2 Antagonists |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Statins |

Rx: Enlyte #30 1 Per Day AM

(Preferred on all Texas Medicaid Plans for Children, Adolescents, and Adults with no Prior Auth)

Refills: _____

Prescriber Signature: _____

Date: _____