



# Consent Form

Date: \_\_\_\_\_  
(Consent form valid for 6 months)

## PATIENT INFORMATION & CONSENT

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

**Product to be used: (check one)**

KetoCal 4:1       KetoCal 3:1

I consent to the health professional indicated below disclosing my personal information to Nutricia North America for the purpose of directing Nutricia to provide me with the KetoCal product checked above. I also consent Nutricia to collecting, using and disclosing my personal information for the purpose of providing me with the requested product.

Patient Signature (or Signature of Guardian): \_\_\_\_\_

Health Professional's Name: (please print) \_\_\_\_\_

License #: \_\_\_\_\_

Medical Institution: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

I hereby confirm that the above noted patient is required to take KetoCal.

Signature: \_\_\_\_\_

## CONTACT INFORMATION

**Nutricia North America**

For product information or to place an order: 800-365-7354

Fax completed consent form to: 301-795-2301

[www.nutricia-na.com](http://www.nutricia-na.com)

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