Consent Form

Date: ___________________________

(Consent form valid for 1 year)

PATIENT INFORMATION & CONSENT

Name: ____ DOB: ________________

Address: ____

City: ___________________________________ State: _________ Zip Code: ____________

Phone: (______) ________________________ Email: ______________________________

Diagnosis: ____

Product(s) to be used:

○ Periflex Infant	○ Periflex Junior	○ Periflex Advance
○ Analog __________	○ Maxamaid __________	○ Maxamum __________
○ Phlexy-10 __________	○ Lophlex	○ Acerflex
○ Lanaflex	○ Complete Amino Acid Mix	○ Essential Amino Acid Mix
○ Monogen	○ Milupa __________	○ Other __________

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 selected metabolic 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): ____________________________________

CHECK HERE IF CONSENT RECEIVED VIA PHONE: ○

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 the selected metabolic product checked above.

Signature: ____

Nutricia North America
For product information or to place an order: 800-365-7354
Fax completed consent form to: 301-795-2301

9900 Belward Campus Drive, Suite 100 § Rockville, MD 20850
Tel: 301.795.2300 § Toll Free: 800.365.7354 § Fax: 301.795.2301

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