



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: 301-795-2302

www.nutricia-na.com

9900 Belward Campus Drive, Suite 100 § Rockville, MD 20850
Tel: 301.795.2300 § Toll Free: 800.365.7354 § Fax: 301.795.2302