

Sample Authorization Request and Consent Form

Please Print

PATIENT INFORMATION & CONSENT

Patient's Name: _____

DOB: _____ Diagnosis: _____

If minor, Parent/Caregiver name: _____

Shipping Address (No P.O. Box): _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

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 below. I also consent Nutricia to collecting, using and disclosing my personal information for the purpose of providing me with the requested product

Signature: _____

PRODUCT REQUEST

- | | |
|---|---|
| <input type="checkbox"/> KetoCal® 3:1 Powder | <input type="checkbox"/> KetoCal® 2.5:1 Liquid (Vanilla) with MCT oil |
| <input type="checkbox"/> KetoCal® 4:1 Powder | <input type="checkbox"/> Liquigen® {Emulsified MCT Oil} |
| <input type="checkbox"/> KetoCal 4:1® Liquid (Vanilla) | <input type="checkbox"/> Phlexy-Vits® |
| <input type="checkbox"/> KetoCal 4:1® Liquid (Unflavored) | <input type="checkbox"/> Ketogenic Diet Starter kit (SKDSK) |
| <input type="checkbox"/> KetoCal 4:1® Liquid (Chocolate) | |

HEALTHCARE PROFESSIONAL INFORMATION

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 authorized to take the selected KetoCal product checked above.

- Please Check: Consent for **Sample Request** through Nutricia North America
 Consent for **KetoCal order** through Nutricia North America

I do not authorize the above-noted patient to receive any KetoCal product noted above.

Signature: _____