



Sample Authorization Request and Consent Form

Date: _____ (Consent form valid for 1 year)

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.

Patient Signature (or Signature of Guardian): _____

PRODUCT REQUEST

- | | | |
|---|---|--|
| <input type="checkbox"/> KetoCal 3:1 Powder | <input type="checkbox"/> KetoCal 4:1 LQ- Vanilla | <input type="checkbox"/> Liquigen |
| <input type="checkbox"/> KetoCal 4:1 Powder | <input type="checkbox"/> KetoCal 4:1 LQ- Unflavored | <input type="checkbox"/> Phlexy-Vits |
| | | <input type="checkbox"/> My Keto Starter Kit |

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

Signature: _____

Nutricia North America -- US

For product information or to place an order: 800.365.7354

Fax completed Form: 301.795.2292

www.MyKetoCal.com • myketocal@nutricia.com

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