

Medical Supervision of Patient

(to be completed by Physician)

Patient's Last Name

Patient's First Name

Patient's Date of Birth (dd/mm/yyyy)

I, the Physician named below, agrees to oversee the above-named patient over the next three (3) months as they adopt a

2:1 ketogenic diet

This medical oversight includes dosages of prescription medications including those used in the treatment of hypertension and/or antiglycemic agents which may need to be adjusted downward, as well as the the periodic monitoring of serum electrolytes.

I am aware that this patient will be self-monitoring serum glucose and serum ketone levels, and that I may elect to periodically assess these at fasting to verify patient measurements.

Physician's Last Name

Physician's First Name

Date (dd/mm/yyyy)

Physician's Signature

Physician's Clinical Address

Physician's Phone Number

unit number and street name

Physician's Fax Number

city, province, postal code