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

○ 3:1 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

unit number and street name

city, province, postal code

Physician's Phone Number

Physician's Fax Number

INSTRUCTIONS TO DOCTOR'S OFFICE: Please fax this signed and dated note to BetterByDesign Nutrition Ltd. at 604-475-7475.