PHYSICIAN OVERSIGHT OF 3:1 KETOGENIC DIET

PATIENT'S LAST NAME:

PATIENT'S FIRST NAME:

PATIENT'S DATE OF BIRTH (dd / mm / yyyy)

I acknowledge that I have been informed that the patient named above wants to undertake a 3:1 ketogenic diet for a period of three (3) months, with the goal of achieving *therapeutic ketosis*, with serum ketones ranging between 2.0 and 3.5 mmol/L and is seeking medical oversight of their Physician or if applicable their Oncologist or Psychiatrist before proceeding.

The Registered Dietitian will assess the patient, design a 3:1 ketogenic diet to meet the patient's nutritional needs, provide individualized nutrition counselling and meal planning, educate the patient regarding blood glucose and blood ketone monitoring, and advise the patient to contact my office if clinically significant nutrition concerns arise that require medical assessment.

I am aware that this patient will be self-monitoring serum glucose daily and will be monitoring serum ketones several times per week. The patient has been advised not to allow their blood glucose to fall below 4.0 mmol/L, or their serum ketones rise above 3.5 mmol/L. The patient has been instructed to contact my office promptly if blood glucose remains at or below 3.9 mmol/L and if serum ketones exceed 3.5 mmol/L.

During the trial period, I will provide ongoing medical management as clinically appropriate, which may include laboratory monitoring of serum glucose, serum ketones, electrolytes, lipid profile, or other investigations deemed appropriate. I will also review the patient's medications and adjust dosages as clinically indicated during implementation of the diet.

Physician's Name (First, Initial, Last**):**

Physician's Clinical Address: (Street Number & Name, City, Province, Postal Code)**:**

Physician's Phone Number:

Physician's Fax Number:

Physician's Signature:

Date Signed (dd / mm / yyyy):

INSTRUCTIONS TO THE MEDICAL OFFICE: Please fax this signed and dated form to BetterByDesign Nutrition at 604-475-7475