THE IDEAL YOU
WEIGHT LOSS CENTER

Open House: _____

Date: _____

Doctor's Name: _____

Group Name: _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

Patient's Name (please print): _____

Patient's Date of Birth: _____ **Patient's Phone Number:** _____

I, _____, hereby give permission for my patient named above to be on a low-calorie, low-carbohydrate, low-fat diet for weight loss. Patient/dieter will be taking a Multi Vitamin, Calcium-Magnesium, Potassium, and Omega 3. There are no appetite suppressants on this protocol.

X_____

Doctor's signature above Date

PLEASE SELECT WHICH IDEAL YOU WEIGHT LOSS CENTER YOU WOULD LIKE TO ATTEND:

☐ **CLARENCE LOCATION (8241 SHERIDAN DRIVE)**
☐ **WEST SENECA LOCATION (SOUTHGATE PLAZA)**

ALL FORMS ARE TO BE FAXED DIRECTLY TO THE IDEAL YOU WEIGHT LOSS CENTER BY THE DOCTOR'S OFFICE

Please fax to: The Ideal You Weight Loss Center @ 716-632-SLIM (7546)

The Ideal You Weight Loss Center
8241 Sheridan Drive, Williamsville, NY 14221/ Southgate Plaza: 1066 Union Rd, West Seneca, NY 14224
Sheridan Location: 716-631-THIN (8446) Southgate Plaza: 716-675- THIN (8446) Fax: 716-632-SLIM (7546)