DOCTOR'S INFORMATION

Open House: _____

Date: _____

Doctor's Name: _____

Group Name: _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

PATIENT'S INFORMATION

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/client 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 / Southgate Plaza: 1066 Union Rd, West Seneca

Phone: 716-631-THIN (8446) Fax: 716-632-SLIM (7546) Website: www.IdealYou.com E-mail: manager@idealyou.com