

**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)
- TONAWANDA LOCATION (2560 SHERIDAN DRIVE)

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 / 2560 Sheridan Drive, Tonawanda
Phone: 716-631-THIN (8446) Fax: 716-632-SLIM (7546) Website: www.IdealYou.com E-mail: manager@idealyou.com