Date: _____ Open House: _____

DOCTOR'S INFORMATION

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 protein based low-calorie, low-carbohydrate, low-fat diet for weight loss. The food products on this protocol each contain 15-20g of protein, and the number of products the patient/client has per day will depend on their starting weight. Patients/clients under 240 lbs will consume 3 products per day (45-60g of protein). Patients/clients between 240 lbs and 300 lbs will consume 4 products per day (60-80g of protein). Patients/clients over 300 lbs will consume 5 products per day (75-100g of protein). All patients/clients will have 4-6oz of animal protein or tofu for dinner plus 4 cups of vegetables throughout the day. Patient/client will also take 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 (1066 UNION ROAD)**
- ☐ **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