The Low Carb Healthy Fat Dietitian

Iron Option Form

Full Name (First, Middle Initial, Last):			
Former Name/ Maiden Name (if applicable):			
Date of Birth (DD / MM / YYYY):		Current Age (in years):	
Gender:	Male ☐	Female ☐	
Street Address (number,street name, apt #):			
Mailing Address (if different than above):			
City:		Province/State:	
Country:		Postal Code/Zip:	
Occupation:			
Phone Number(s) with area code:			
Email:			
Emergency Contact Name:		Emergency Contact Number:	
MD's Name:		MD's Phone Number:	
MD Diagnosis (list all):			
MD Recommendations:			
How did you hear about us?	Please select an item from the dropdown menu		
Please enter specific details (name of friend, doctor, event, etc.):			
Is there a mental health component to this consultation?	◯ Yes	◯ No	
Kind of nutrition support you have had:			
Previous diets followed (if any):			
Date of Last Blood Tests: (required):		Abnormal Results: ◯ Yes	◯ No
Current Blood Pressure: (required):		Date of Blood Pressure: (required):	

Note: Please send a pdf (Adobe) copy of your **most recent complete blood test results** with **this form** to info@lchf-rd.com.. If you don't have current complete blood work, we can get started without it, however I will need it to design your Meal Plan.

Please select mode of service (required): ☐ in person (Coquitlam office) ☐ Distance Consultation services (phone/skype)

Do you have extended benefits (required): ◯ Yes ◯ No

Extended Benefits provider (required):

Extended benefit limits for visits to a Dietitian (required): $ / year

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Prices are in **Canadian dollars (CDN).** GST (5%) will be added.

Please tick off the chosen service:

☐ **IRON OPTION:** to address iron deficiency / insufficiency

The Iron Option is an add-on service to the Complete Assessment Package (CAP) and provides TWO Nutrition Education Sessions to (1) improve iron absorption & (2) minimize interference from other foods or nutrients. The first Iron Option teaching takes place after the Nutrition Education Session for the Meal Plan (final visit of the CAP) and the second Iron Option teaching takes place ~2-3 weeks later (or when initiated by me, the client). $100

STATEMENT OF UNDERSTANDING:

I hearby understand and accept that this Iron Option form serves as an addendum to the **Intake and Service Option Form** that I completed on (DD/MM/YYYY) (required) _____ and all terms listed on that form apply.

I attest that I am seeking nutrition consultation session(s) on my own behalf in order to learn nutritional and lifestyle information that I may apply in everyday life.

I understand and accept that the services offered by Joy Y. Kiddie, MSc RD of The LCHF-Dietitian (a division of BetterByDesign Nutrition Ltd.) do not involve medical diagnosis or treatment of any disease, unless explicitly provided by written referral from my physician, and that I am providing lab tests results for information purposes only.

I understand and accept that I am fully responsible for my own health as it relates to appointment with the Dietitian and that the recommendations provided to me by the Dietitian do not replace or subsitute for the diagnoses and treatment recommendations of my physician(s).

I understand and accept that it is my responsibility to consult with my physician [or in the absense of one, with a physician at a local walk-in clinic] with regards to implementing any recommendations provided to me by the Dietitian prior to changing my dietary intake, eating pattern and/or physical activity.

I understand and accept that it is my responsibility to have clarifed anything I do not understand on this form with the Dietitian, prior to beginning services.

I understand and accept that Joy Y. Kiddie MSc, RD of The LCHF-Dietitian (a division of BetterByDesign Nutrition Ltd.) has the right to refuse treatment or terminate provision of services.

CONSENT FOR NUTRITION SERVICES

I understand and accept that there are both benefits and risks involved with any nutrition or physical activity recommendations and I have, or will consult with my physician before implementing any nutritional, exercise or lifestyle recommendations provided to me by the Dietitian.

I understand and accept that this consent expires six (6) months from the date indicated directly below.

I hereby give my consent for the above indicated services.

Client's First Name, Middle Initial, Last Name: (required) _____

☐ By checking off this box, I declare that I have read this form, understand and agree with its contents.

☐ By checking off this box, I agree to all the terms above and understand that my typed name below is as legally binding as my physical signature.

Client's signature: _____ **Date:** (required) _____