



Consent Form

Date: _____
(Consent form valid for 1 year)

PATIENT INFORMATION & CONSENT

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) _____

Diagnosis: _____

Product(s) to be used:

Analog _____ product name Maxamaid _____ product name Maxamum _____ product name

Lophlex Periflex Junior Periflex Advance Milupa _____ product name

Complete Amino Acid Mix Essential Amino Acid Mix Phlexy-10 _____ product name

Monogen Lanaflex Acerflex (MSUD) Other _____ product name

I consent to the health professional indicated below disclosing my personal information to Nutricia North America for the purpose of directing Nutricia to provide me with the selected metabolic product checked above. I also consent Nutricia to collecting, using and disclosing my personal information for the purpose of providing me with the requested product.

Patient Signature (or Signature of Guardian): _____

Health Professional's Name: (please print) _____

License #: _____

Medical Institution: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) _____ Fax: (____) _____

I hereby confirm that the above noted patient is required to take the selected metabolic product checked above.

Signature: _____

Nutricia North America

For product information or to place an order: 800-365-7354
Fax completed consent form to: 301-795-2292

9900 Belward Campus Drive, Suite 100 § Rockville, MD 20850
Tel: 301.795.2300 § Toll Free: 800.365.7354 § Fax: 301.795.2302