KETOGENIC DIET REFERRAL

Physician Name: _____

Physician Address: _____

_____

Physician Phone: _____

Physician FAX: _____

Physician email: _____

Patient Name/DOB: _____

Patient Address: _____

_____

Patient Cancer Diagnosis: _____

Patient Secondary Diagnoses: _____

By referring the above patient for Ketogenic Diet Therapy, I certify that he/she has no known mitochondrial disorders or a primary carnitine deficiency, which would contraindicate the use of the Ketogenic Diet as an experimental treatment for cancer.

I agree to order and monitor lab work, along with the Registered Dietitian, as well as prescribe KPhos Neutral as a dietary supplement.

I will communicate with the Registered Dietitian via phone/email PRN.

Signature:_____

Name (printed):_____

Return to: Denise Potter RD, CSP, CDE
Ketogenic Therapies, LLC
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Petersburg, MI 49270
denise@ketogenictherapies.com