BBD Nutrition

Nutrition is BetterByDesign

Intake Form and Service 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@bbdnutrition.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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In one sentence, please describe your goals and expectations and lifestyle changes you would like to make. Please be as specific as possible:

Please list any physical or mental health illnesses or conditions that run in your family (parents, grandparents, siblings):

Please list any medical conditions that you have been diagnosed with (e.g.Type 2 Diabetes, hypertension, high cholesterol, etc.)

Please list all physician-diagnosed allergies that you have (foods, drugs, environmental):

Please list any food intolerances you have (foods that make you feel unwell):

Please list the names of all **medications** and/or **nutritional supplements** currently being taken, as well as the dosage:

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Please tick off services requested:

1. HOURLY SESSIONS:

☐ **Hourly Clinical Services:** provides the services as available under one of the packages, but on an hourly basis. Please note that a copy of recent complete blood work is required. — $150 / hr

2. COMPLETE ASSESSMENT PACKAGE: only for the routine clinical conditions listed below.

Please use the Customized Nutrition Package if there are other / additional clinical conditions.

☐ **Complete Assessment Package** is an all-inclusive package for clients who want to eat healthier, lose weight and lower their insulin resistance. Includes a one-hour initial appointment to establish dietary goals, collect personal and family medical history, review any recent laboratory tests and conduct a complete food habit and lifestyle review. Based on the information collected, an Individual Meal Plan will be designed factoring in your weight management goals. Review of your Meal Plan, teaching of simple yet accurate ways to estimate portion sizes, and answering questions will take place during the final one-hour Nutrition Education Session. — $350 / pkg

☐ **PEDIATRIC** - aged 6 - 19 years, includes ht / age, wt / age, BMI / age, growth projection . . . . . + $50

Select all ROUTINE CLINICAL CONDITIONS:

☐ **Hypertension** (high blood pressure)

☐ **Insulin Resistant** (high blood sugar)

☐ **Dyslipidemia** (abnormal cholesterol)

☐ **Type 2 Diabetes**

3. FOLLOW-UP PACKAGES:

☐ **Dietary Management Package:** The Dietary Management Package is a follow-up package for those who've taken the Complete Assessment Package and would like additional support or 'coaching'. The Dietary Management Package can be taken as 6 half-hour sessions or as 3 one hour-sessions – or a combination of full hour and half hour sessions totalling 3 hours of services. — $350 / pkg

☐ **Anti-Inflammatory Protocol Package:** designed to help people learn which foods promote inflammation so that they can limit them and which foods are evidence-based to have anti-inflammatory properties in order to increase intake of them, with the goal of reducing pain & symptoms. — $350 / pkg

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4. CUSTOMIZED SERVICES:

☐ **Customized Nutrition Package:** please specify services sought (not described under existing packages) and price requested for those services:

To be completed by the Dietitian:

I agree to provide the services outlined in the Customized Nutrition Package description at the following cost: $_____

Registered Dietitian's Printed Name:

Date Signed: Day Month Year:

5. SPECIALIZED SERVICES:

☐ **Food Sensitivity / Food Allergy Management Package:** designed for clients who suspect they may be sensitized to certain foods or components of foods. Uses a combination of standard assessment tools and where appropriate, will request the client's MD to requisition IgE specific serum antibody allergy testing (covered by MSP) to determine whether antibodies to specific foods / food classes are present. Includes 3 one-hour visits or a total of 3 hours of services. $350 / pkg

☐ **Celiac Disease Management Package:** specifically designed to cover each of the topics listed on the Canadian Celiac Association's web page in sufficient detail so as to enable a newly diagnosed Celiac to safely select foods and ingredients at home and away from home. This package will also fill in 'gaps' in knowledge in celiacs who have been diagnosed for some time or those who need to avoid gluten for other reasons. Includes 2 x 1.5 hour appointments. *Topics include;* $350 / pkg

1. What is Celiac Disease
2. Nutrition Complications in Celiac Disease
3. Getting Started – what to eat at first
4. Ingredients
5. Gluten-Free Food Ingredients list
6. Non-Gluten-Free Food Ingredients
7. Gluten-Free Alcoholic Beverages list
8. What does "Gluten-Free" in alcoholic beverages mean?
9. Gluten-Free Shopping in the Lower Mainland
10. Gluten Sources in Medications & Gluten-Free Medications
11. Avoiding Cross-Contamination in Food Preparation
12. Lower Mainland Restaurants
13. Celiac Medical Expenses for Tax Deductions
14. Recommended Resources – in print and online

☐ **Irritable Bowel Syndrome (IBS) Package:** is designed for clients who have had clinical conditions such as Inflammatory Bowel Disorder (Crohn's, Colitis etc.) and Celiac disease ruled out and who require support to determine which foods or food components and/or beverages are contributing to their ongoing, unpleasant gastro-intestinal symptoms. Includes 3 one-hour visits or a total of 3 hours of services. $350 / pkg

DISTANCE CONSULTATION and REGISTERED DIETITIAN REGISTRATION

For those taking Distance Consultation service, please note that my clinical office and place of business is British Columbia, Canada and I am registered with the College of Dietitians of British Columbia. Distance Consultation services will be deemed to have taken place at my Coquitlam, British Columbia office.

SELECTION OF PACKAGES and PACKAGE EXPIRY

Complete blood test results will need to be received prior to the design of the Individual Meal Plan for those taking a Complete Assessment Package but the package may be started pending their reception. Packages must be completed within 6 months from the date indicated at the bottom of this form, after which they will be deemed to have expired.

PAYMENT METHODS, RECEIPTS and CANCELLATION OF SERVICES

Payment shall be made 24-hours' in advance of the first scheduled appointment in Canadian dollars (CDN) either by e-transfer sent to info@bbdnutrition.com (and using the security word provided) or paid directly on our SSL encrypted web page (www.bbdnutrition.com/shop) by credit card. If attending appointments in-person, payment for services may be made via personal cheque made out to BBDNutrition Ltd.

A flexible payment plan is available for the Complete Assessment Package, with payments as follows: $150 paid 24 hours' prior to the assessment appointment, $100 paid prior to design of Meal Plan, $100 paid prior to Nutrition Education Session.

Payments for packages that have already begun are non-refundable, however should our office receive written notice requesting cancellation of services 7 days or more prior to the first confirmed appointment, a full refund will be provided via e-transfer within 7 business days.

APPOINTMENT CANCELLATION, RESCHEDULING and 'NO-SHOWS'

Cancellation or rescheduling of an appointment with less than 24 hours' written notice will result in a $150.00 charge being applied.

Failure to keep an appointment ('no-shows') will be considered as a completed visit.

CONFIDENTIALITY

All discussions with the Dietitian and all records related to nutritional services are confidential and will not be shared with any other person, health care provider or organization without prior knowledge and written consent of the client.

For reasons of client confidentiality, Intake and Service Option Forms must be completed by the client and emailed to the office by them from their own email account.

For confidentiality, laboratory test results should have confidential information redacted prior to emailing to us.

ROLE OF THE CLIENT'S PHYSICIAN:

The client's physician is responsible for overseeing their healthcare, and it is the client's responsibility to inform their physician that they are planning to consult with a Registered Dietitian. If their physician has specific dietary recommendations, the client will request that their physician write a referral to the Dietitian with their instructions.

If the client does not have a General Practice / Family Practice Physician, they will consult with a physician at walk-in clinic regarding their intention to see a Registered Dietitian and will ask them if they have any specific recommendations.

If the client has been prescribed medications to control their blood sugar, cholesterol or blood pressure, they understand that it is their responsiblity to ensure that they have a physician monitor their medication dosage as they lose weight.

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STATEMENT OF UNDERSTANDING:

I hereby 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 BetterByDesignNutrition 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 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: (required)

Date: (required)