Low-FODMAP 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

Nutrition is BetterByDesign

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

Please tick off the chosen service:

☐ **LOW-FODMAP OPTION:** which are high FODMAP foods to avoid eating with IBS. $75

The Low-FODMAP Option is an add-on service to the Complete Assessment Package (CAP) and provides an additional Nutrition Education Session in order to teach which foods should be limited or avoided in order to reduce symptoms related to Irritable Bowel Syndrome (IBS).
NOTE: This same nutrition education is available as an Hourly Consultation, without taking a Complete Assessment Package (CAP).

STATEMENT OF UNDERSTANDING:

I hearby understand and accept that this Diverticulosis 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 here.

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 BetterByDesign Nutrition Ltd. / BBDNutrition 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. / BBDNutrition 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) _____