Ph@tt®
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HEALTH CARE PRACTITIONER CONSENT FORM

Date: ____________________

Name of patient: ____________________

Current medical condition/s:

____

____

☐ I have reviewed the fact sheets of the products provided to me by my patient and have considered the Ph@tt program as presented to me.

☐ I approve the participation of ________________________(insert name) in the Ph@tt program with all products

☐ I approve the participation of ____________________ in the Ph@tt program but recommend omitting certain products due to _______________ (insert name)'s current medical condition/s;

☐ I do NOT approve the participation of _________________ in the Ph@tt program.

Dr _

Dr Signature _

Practice Stamp:

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PARTICIPANT CONSENT FORM

Date: ____________________

Name: ____________________

My current medical condition/s is:

____

____

☐ I confirm that I have visited my Healthcare Practitioner / Pharmacist and presented the fact sheets of products provided to me by my mentor. I have also explained to my GP the Ph@tt program.

☐ I confirm that I have been given approval to participate in the Ph@tt program with all products

☐ I confirm that I have been given approval to participate in the Ph@tt program with suggested omission of the products [insert products to be omitted] due to my current medical condition/s;

☐ I have NOT seen or been given approval from my Healthcare Practitioner / Pharmacist to participate in the Ph@tt program however, I wish to proceed and take full responsibility.

Name of participant _

Signature of Participant_ _