❑ 12 Haviland Road, Queensbury NY 12804
Phone: 518-793-5555
thegerberdiet.com

Physician Name: ____

Address: ____

Phone: ____________________ Fax: ____________________

RE: Patient Name: ______________________________ DOB: ______________

Phone #: ______________________________

Your patient has expressed a desire to participate in The Gerber Diet medically-developed weight loss program. Because he/she is currently under your care, we would like your approval before starting him/her on the program.

Dieters are seen weekly to monitor their progress and will be taking the following supplements: multi-vitamin, essential mineral supplement, and omega 3. There are no appetite suppressants on this protocol. Since many patients who enter our program can reduce or discontinue medications such as anti-hypertensives, oral hypoglycemic, insulin, etc., your patient understands the importance of keeping your office informed of their progress, in the event a change in medication becomes necessary. If you have any questions or want to request further information, please contact us at the number listed above.

Please feel free to refer other patients who would benefit from weight loss. Thank you!

If you agree that your patient would benefit from weight loss and can participate in The Gerber Diet program, please sign below and return by fax.

____

Provider Name (printed):

____

Provider Signature Date

Please fax signed form to:

518-793-5551