



To order Cyto-Q, consent must first be given by a healthcare professional specialized in mitochondrial disorders.

Date: _____ (consent valid for 12 months)

Patient has been diagnosed with a mitochondrial disorder Yes No

Patient Information

Patient's Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone Number: (____) _____

Healthcare Professional Information

Prescriber's Name: _____

License #: _____

Signature: _____

Medical Institution: _____

Address: _____

Address: _____

City: _____ State: _____

Zip Code: _____

Phone #: (____) _____ Fax #: (____) _____

Please fax completed consent form to: Solace Nutrition at (401)633-6066

Products designed by healthcare professionals