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To order Cyto-Q or Cyto-Q MAX, 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*