

Vitamin Contract

Name _____ DOB _____

Provider _____ Date of service _____

MRN _____

_____ I agree to use only Bariatric Advantage or Celebrate multivitamin. I understand that vitamin gummies, patches, doTerra supplements, extended release formulas, Tespo pods, gel caps or vitamin capsules are not recommended.

_____ I agree to purchase recommended doses and forms of vitamins and follow the vitamin prescription determined by a WLWC dietitian.

_____ If I want to change my vitamins or my vitamin schedule, I will discuss desired changes with the WLWC dietitian first.

_____ I understand if I do not follow the recommended vitamin schedule, I could develop lifelong nutritional deficiencies that may be irreversible and potentially life-threatening.

_____ I will try to complete my labs two weeks prior to scheduled visits with the medical provider and/or dietitian. I understand if I complete labs after these visits, I may be asked to schedule with these providers again to review the results.

_____ I understand my iron supplement cannot be taken within two hours of any dairy products, calcium supplements, coffee or tea, because it will reduce absorption of iron.

_____ I understand that I cannot take multiple doses of my calcium supplement at the same time because I can only absorb a limited amount of calcium at one time.

_____ I agree to read the entire handout: Daily Dose on Vitamins and Minerals.

_____ I agree to notify the dietitian or WLWC medical staff of any signs or symptoms that could be associated with deficiencies listed in the Daily Dose on Vitamins and Minerals.

Patient signature _____ Date _____