Network of 500+ Clinics

Dr BRC Clinic@home

Daily Diet and Medication Form

Patient Details	WISE Expert Details
Date: _____	Name: _____ Age: _____
Name: _____	Mobile: _____
Email: _____	Email: _____
Mobile: _____ Profession: _____	City: _____ State: _____
Gender: _____ Age: _____ Weight: _____ Height: _____	**Consultation charges:** _____
Address: _____	**Payment mode:** PayTM / Bank Transfer / Cash _____
_____	**HQ Consultation Fee:** Paid / Unpaid _____

Language in which you want a diet plan: Hindi: _____, **English:** _____

Do you smoke: _____ **Do you consume alcohol:** _____ **Allergies (Food):** _____

Vegetarian: _____ **non-Vegetarian:** _____

Present Status of your teeth/Can you chew raw food comfortably: _____

Medical condition(s)/Disease(s): _____

_____

Name of the Medications taken along with dosage: (CAPITAL LETTERS)

_____

_____

Duration: For how long have you been taking this/these medicine(s) _____

If kidney issues, please fill details:

Undergoing dialysis, if yes, frequency: _____

Urine output (24 hrs): _____ ml Swelling: _____ Weakness: _____

Nasea/Vomiting: _____ Breathlessness: _____

KFT Parameters:

Creatinine: _____ Urea: _____ GFR: _____

Pottasium: _____ HB: _____ Calcium: _____

If diabetic, please mention your readings:

HbA1c: _____ Fasting: _____ PP (Lunch): _____ PP (Dinner): _____

If hypertensive, please mention your readings:

Blood pressure (morning): _____ Blood pressure (evening): _____

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Other issues:

Acidity: _____ Constipation: _____ Loose motion: _____ Lump: _____ Wound/Lesion: _____

Do have any Discomfort / symptoms / Unusual Feeling presently? (MANDATORY TO ANSWER. Please write **'NO DISCOMFORT'** in-case you do not have any discomfort or symptoms.

_____

_____

Do you have any pain? If yes, please name the area which is paining and intensity of pain on a scale of 1-10: _____

Number of Blood Transfusion (e.g. 1 per week, 2 per month etc.): _____

_____

Are you vaccinated for COVID-19: _____

Please Mention the name and year of the surgery / surgeries undergone, if any: _____

Out of 24hrs, how many hours you spend sitting? (office / home / work from home): _____

Your Daily Diet:

Early morning, the first thing you eat / drink: _____

Breakfast: _____

10 am – 12 noon: Mid-morning Snacks: _____

Lunch: _____

4 pm – 7 pm: Evening Snacks: _____

8 pm – 10 pm: Dinner: _____

Late night snack: _____

Physical Activity:

Morning: _____ Afternoon: _____

Evening and Night: _____

I ..... **s/o**..... authorize Dr. BRC Clinic@home and its WISE team to Treat me as per their treatment plan.

Note: The fee once paid is non-refundable.

Name: _____

Signature: _____ **Date:** _____

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Consent Form

1. I am aware that this is an online program and all the advice is provided through email or other digital media via WISE expert.

2. I hereby consent to follow the medicine tapering advice given by the system, which recommends interventions in terms of introduction of appropriate food in recommended quantity time to time and accordingly advises to taper the medicine. I understand that the system works on data collected from treatment of tens of thousands of people. I am willing and ready to participate in this program of my own free will, without any influence or coercion and I am following the advice at my own volition and I haven't been induced or coaxed in whatsoever manner or mode.

3. I understand that during the course of this program few unforeseen conditions and complications/ medical emergencies may arise demanding immediate conventional medical treatment, which I will promptly seek without delay.

4. I had been given ample opportunity to inquire/interrogate/ask any of my queries/questions/doubts. Dr. BRC Clinic@home has properly addressed and answered all my queries/questions/doubts to my satisfaction and have not forced me to take their treatment by any means.

5. I fully understand and further acknowledge that no guarantee/promise has been made to me regarding the outcome of the course and have been properly briefed about the result, and the unforeseen risks/complications arising during or after the course.

6. In addition to above me and my other family members/well wishers further agree that Dr. BRC Clinic@home will not be held responsible in any manner, whatsoever, for any medical deterioration or demise during the course of treatment or any other further complication arising out of it.

7. I agree and understand that under confidentiality act, the personal information of patients is kept confidential and will not be disclosed.

8. I understand that dietary intervention/diet plan cannot address any emergency arising due to heart-attack, stroke, organ failure, injuries etc and in such cases I will immediately seek emergency services from nearby hospital/clinic.

9. All disputes shall be subject to the Faridabad jurisdiction/court only.

I hereby certify and endorse that this consent form is filled in my presence and to my willingness to undertake this medical treatment after making me and my well wishers understand the complete course and all other liabilities/risks which may arise during or later on.

Name: _____

Signature: _____ **Date:** _____