

## Professional Questionnaire for FOD Referral Purposes

*All Medical/Health Professionals: Please complete this Questionnaire if you would like Families to know that you diagnose, clinically treat and/or do research with Fatty Oxidation Disorder Children and/or Adults. Please return via email (copy and paste) or fax or regular mail.*

**Name:** \_\_\_\_\_

**Professional Title:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Webpage:** \_\_\_\_\_

**Specialty:** \_\_\_\_\_

**I have access to lab facilities to test for/diagnose FODs:** \_\_\_ Yes \_\_\_ No

**I clinically treat (Y or N) \_\_\_ children and/or \_\_\_ adults with an FOD diagnosis**

**Specific FODs treated:** \_\_\_\_\_

**Other Metabolic Disorders treated:** \_\_\_\_\_

**I conduct research involving FODs:** \_\_\_ Yes \_\_\_ No

**Main research area:** \_\_\_\_\_

\_\_\_\_\_

**How should contact or Referrals be made? By the child's/adult's Dr \_\_\_ or can families actually call your main office and talk with you or staff personnel \_\_\_**

*Thank you!*

*Deb Lee Gould, Director, FOD Family Support Group [www.fodsupport.org](http://www.fodsupport.org) [deb@fodsupport.org](mailto:deb@fodsupport.org)  
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