115 Marcon Drive
Lafayette, LA 70507

NATIONAL TOTAL CARE Services, LLC

337-291-9919
337-291-9920(fax)
1-877-236-6687(toll free)

MEDICAID ORAL SUPPLEMENT REFERRAL FORM

DEMOGRAPHIC INFORMATION

PATIENT:_____ DATE: _____
MAILING ADDRESS:_____ PHONE:_____
DELIVERY ADDRESS:_____ SS#:_____
CITY/STATE/ZIP CODE:_____ FOOD ALLERGIES:_____
DATE OF BIRTH:_____ CODE STATUS: No Code or Full Code
MEDICARE #:_____ DIALYSIS / REFERRAL SOURCE:_____
MEDICAID #:_____ DIALYSIS DAYS: MWF or TTS

SUPPLEMENT ORDERED:_____ FREQUENCY:_____TIMES PER DAY FLAVOR_____
_____ _____ _____
_____ _____ _____
_____ _____ _____

THIS PATIENT IS ALLOWED TO HAVE CHOCOLATE FLAVORED SUPPLEMENTS? YES or NO

THIS SUPPLEMENT CONSTITUTES 70% OF THE PATIENTS DAILY INTAKE OF _____CALORIES. THIS PATIENT IS UNABLE TO TOLERATE AN ADEQUATE AMOUNT OF NUTRITIOUS FOOD DUE TO:_____

DIAGNOSIS INFORMATION

_____END STAGE RENAL DISEASE
_____HYPOALUBUMINEMIA(ALB LEVEL=_____)
_____ANOREXIA(DUE TO_____)
_____HIV & /OR AIDS
_____CANCER OF _____
_____CEREBROVASCULAR ACCIDENT
_____MULTIPLE SCLEROSIS
_____MALNUTRITION (DUE TO _____)
_____ALZHEIMER DISEASE (END STAGE)
_____PARKINSON DISEASE (END STAGE)
_____DEMENTIA / ORGANIC BRAIN SYNDROME
_____MENTAL RETARDATION
_____DIABETES MELLITUS (_____INSULIN DEPENDENT, _____NON-INSULIN DEPENDENT)
_____COPD
_____CONGESTIVE HEART FAILURE
OTHER:_____

MENTAL STATUS:

_____AWAKE, ALERT & ORENTED
_____FORGETFUL
_____DEPRESSED
_____DISORIENTED / CONFUSED

HEIGHT & WEIGHT:

_____HEIGHT
_____WEIGHT

PLEASE PROVIDE SUPPORTING DOCUMENTATION FOR ALL DIAGNOSIS LISTED!

COMMENTS:_____
_____

REFERRAL SOURCE INFORMATION:

_____ _____
REFERRAL SOURCE NAME CONTACT PERSON (PLEASE PRINT)

_____ _____
REFERRAL SOURCE ADDRESS REFERRAL SOURCE PHONE NUMBER

_____ X _____
PHYSICIAN ORDERING SUPPLEMENT (please print) **PHYSICIAN SIGNATURE**(Must be signed in order to submit)