

MEDICAID ORAL SUPPLEMENT PRESCRIPTION FORM

PATIENT DEMOGRAPHICS

DATE: _____

PATIENT: _____ PHONE: _____
 ADDRESS: _____ DATE OF BIRTH: _____
 CITY/STATE/ZIP: _____ SS#: _____
 FOOD ALLERGIES: _____ MEDICAID #: _____
 HEIGHT: _____ (CM) / WEIGHT: _____ (LB)

| | SUPPLEMENT(S) ORDERED | FREQUENCY (TIMES PER DAY) | FLAVOR(S) | CALORIES PER DAY |
|-----|-----------------------|---------------------------|-----------|------------------|
| 1 - | | | | |
| 2 - | | | | |
| 3 - | | | | |
| 4 - | | | | |

TOTAL CALORIES FROM SUPPLEMENTS: _____

This supplement constitutes at least 70% of the patient's daily caloric intake of _____ calories. If **TOTAL CALORIES FROM SUPPLEMENTS** are LESS than 750 calories, physician documentation **MUST** accompany this prescription to justify the patients' need!

- This patient is unable to tolerate an adequate amount of nutritious food due to: _____.
- This nutritional supplement is medically necessary for dietary maintenance in End Stage Renal Disease (ESRD).

MENTAL STATUS

_____ Awake, Alert & Oriented _____ Forgetful _____ Depressed _____ Disoriented / Confused

DIAGNOSIS - supporting documentation required for all diagnosis indicated

- _____ End Stage Renal Disease
- _____ Hypoalbuminemia (ALB LEVEL = _____)
- _____ Anorexia (Due To _____)
- _____ HIV and/or AIDS
- _____ Cancer: _____
- _____ Dysphagia
- _____ Other: _____
- _____ Failure To Thrive
- _____ Malnutrition (Due To: _____)
- _____ Mental Retardation
- _____ Diabetes Mellitus (___ IDDM or ___ NIDDM)
- _____ COPD
- _____ Congestive Health Failure

ORDERED BY:

FACILITY NAME

FACILITY ADDRESS

PHONE NUMBER AND FAX

FACILITY CONTACT PERSON

PRESCRIBER'S PRINTED NAME

X _____
PRESCRIBER'S SIGNATURE