115 Marcon Drive
Lafayette, LA 7050

TotalCare

337-291-9919 (Phone)
337-291-9920 (Fax)

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	ALLOW SUBSITUTION (✓)	FREQUENCY (TIMES PER DAY)	FLAVOR(S)	CALORIES PER DAY
1 -					
2 -					
3 -					

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 CONTACT PERSON

_____ FACILITY ADDRESS

_____ PRESCRIBER'S PRINTED NAME

_____ PHONE NUMBER AND FAX

X_____ **PRESCRIBER'S SIGNATURE**

This prescription will expire one year from the date it's issued.