CHC
SOLUTIONS, INC.

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ORAL NUTRITION ORDER FORM

Please attach face sheet w/ patient demographics & insurance info
Please attach food logs, lab work, clinical notes and/or any other relevant documentation

PATIENT INFORMATION

Patient Name: ______________________ DOB: ______ /______ /_________ Gender: ☐ Male ☐ Female

Language Pref.: ☐ English ☐ Spanish ☐ Other: __________________

Emergency Contact Name/Phone Number: ______________________

DIAGNOSIS

Primary Diagnosis (Required) ICD-10 Code: ______________	Secondary Diagnosis (Required*) ICD-10 Code: ______________ *Diagnosis must reinforce medical necessity and justification of nutritional products.

PATIENT INFORMATION

Today	Height:______	Weight:______	6 Months Ago	Height:______	Weight:______
3 Months Ago	Height:______	Weight:______	9 Months Ago	Height:______	Weight:______

Body Mass Index (BMI):________________ Albumin:______________________

NUTRITIONAL HISTORY

Please list other formulas trialed:

What were the results of these attempts?

DIETITIAN HISTORY

Has the patient been referred to a dietitian/nutritionist? ☐ Yes ☐ No

If yes, what is the name of dietitian/nutritionist? ______________________

Product(s)

Product:	Volume:	Frequency:
1.	_______ ☐ Cans ☐ Scoops ☐ mL	☐ Daily ☐ 2x/day ☐ 3x/day ☐ 4x/day ☐ Other:_____
2.	_______ ☐ Cans ☐ Scoops ☐ mL	☐ Daily ☐ 2x/day ☐ 3x/day ☐ 4x/day ☐ Other:_____
3.	_______ ☐ Cans ☐ Scoops ☐ mL	☐ Daily ☐ 2x/day ☐ 3x/day ☐ 4x/day ☐ Other:_____
4.	_______ ☐ Cans ☐ Scoops ☐ mL	☐ Daily ☐ 2x/day ☐ 3x/day ☐ 4x/day ☐ Other:_____

☐ Thickener:______________________ Consistency: ☐ Honey ☐ Nectar Amount of fluid per day____________mls

Additional information or mixing instructions:

Order Date: _____/______/______ **No. of Refills:** ☐ **6 months** ☐ **12 Months** ☐ **Other:** ___________

REFERRAL INFORMATION

Ref #: ___________________

Practice Name: ______________________ Fax: ______________________

Office Address: ______________________ Email: ______________________

Phone: ______________________ Preferred Method of Contact? ☐ Phone ☐ Fax ☐ Email

Contact Person: ______________________

Physician Name: ______________________ NPI#: ______________ Phone: (_______)_______-__________ Ext. _______

Physician Signature: ______________________ Date: ______ /______ /_________ License: __________________

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Call 1.800.220.5262 or visit www.chcsolutions.com for additional information.

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