



**\*\*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.	_____ <input type="checkbox"/> Cans <input type="checkbox"/> Scoops <input type="checkbox"/> mL	<input type="checkbox"/> Daily <input type="checkbox"/> 2x/day <input type="checkbox"/> 3x/day <input type="checkbox"/> 4x/day <input type="checkbox"/> Other: _____
2.	_____ <input type="checkbox"/> Cans <input type="checkbox"/> Scoops <input type="checkbox"/> mL	<input type="checkbox"/> Daily <input type="checkbox"/> 2x/day <input type="checkbox"/> 3x/day <input type="checkbox"/> 4x/day <input type="checkbox"/> Other: _____
3.	_____ <input type="checkbox"/> Cans <input type="checkbox"/> Scoops <input type="checkbox"/> mL	<input type="checkbox"/> Daily <input type="checkbox"/> 2x/day <input type="checkbox"/> 3x/day <input type="checkbox"/> 4x/day <input type="checkbox"/> Other: _____
4.	_____ <input type="checkbox"/> Cans <input type="checkbox"/> Scoops <input type="checkbox"/> mL	<input type="checkbox"/> Daily <input type="checkbox"/> 2x/day <input type="checkbox"/> 3x/day <input type="checkbox"/> 4x/day <input type="checkbox"/> 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 1.888.248.1975 or visit [www.connectchc.com](http://www.connectchc.com) for additional information.