CHC SOLUTIONS, INC.

**FAX: 1.877.299.7606**
**EMAIL: nutriorders@chcsolutions.com**

# ADULT 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)** | **Secondary Diagnosis (Required*)** |
|---|---|
| **ICD-10 Code:** _____ | **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)

**Adult**

☐Boost: ☐Vanilla ☐Chocolate
☐Boost Plus: ☐Vanilla ☐Chocolate
☐Boost High Protein (Vanilla)
☐Boost Very High Calorie (Vanilla)
☐Boost Glucose Control: ☐Vanilla ☐Chocolate
☐Novasource Renal: ☐Vanilla ☐Strawberry ☐Mocha
☐Compleat Standard 1.4 (Vanilla)
☐Compleat Peptide 1.0 (Vegetable & Fruit Medley)
☐Compleat Peptide 1.5 (Vegetable & Fruit Medley)
☐Peptamen with Prebio (Vanilla)
☐Peptamen 1.5 with Prebio (Vanilla)

**Modular**

☐Benecalorie (Unflavored)
☐MCT Oil (Unflavored)
☐Liquacel: ☐Grape ☐Peach Mango ☐Watermelon

Volume: _____ ☐ Cartons ☐ Scoops ☐ mL

Frequency: ☐1x/day ☐2x/day ☐3x/day ☐4x/day ☐Other:_____

OK to substitute with equivalent product: ☐ Yes ☐ No

Additional information or mixing instructions:

**Order Date: _____/_____/_____**

**No. of Refills: ☐ 6 months ☐ 12 Months ☐ Other: _____**

## REFERRAL INFORMATION

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.