CHC SOLUTIONS, INC.

FAX: 1.877.299.7606
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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? _____

PRODUCTS

Adult

Boost: ☐Vanilla ☐Chocolate
Boost Plus: ☐Vanilla
Boost Glucose Control: ☐Vanilla ☐Chocolate
Novasource Renal: ☐Vanilla ☐Strawberry ☐Mocha
Ensure: ☐Vanilla ☐Chocolate
Ensure Plus: ☐Vanilla ☐Chocolate
Glucerna Shake: ☐Vanilla ☐Chocolate

☐Boost Very High Calorie (Vanilla)
☐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

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.