



PHONE: 1.800.344.1550 FAX: 1.844.317.9379

EMAIL: orders@chcsolutions.com

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: _____ Patient cannot accept deliveries on the following days?
Mon Tues Wed Thurs Fri Sat

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

Table with 4 rows and 3 columns: Today, 3 Months Ago, 6 Months Ago, 9 Months Ago. Columns include Height, Weight, Body Mass Index (BMI), Caloric Needs/Day, Goal Weight, Albumin.

NUTRITIONAL HISTORY

Has any previous attempts been made to treat with? (Check all that apply)
 High Calorie High Protein
 Regular Foods Regular Foods (blenderized)

What were the results of these attempts? _____

Has the patient received any nutritional supplements in the past?: Yes No If yes, did patient gain weight?: Yes No

DIETITIAN HISTORY

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

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

Please provide details why can needs not be met utilizing ordinary food with assistance of dietitian/nutritionist? _____

Product(s)

Table with 3 columns: Product, Dosage, Frequency. Rows 1, 2, 3.

Order Date: ____/____/____ Length of Need: _____ months

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 below, 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.

Assignment of Benefits: I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.

Patient Signature: _____ Date: ____/____/____