Clinical Summary of Patient's Nutrition Status

Completing this form is optional. If you choose to submit it**, please fax it along with the signed prescription and Treatment Authorization Request (TAR) to (831) 430-5851**. Additional clinical documentation, including chart notes and lab values, may also be attached. All age-appropriate growth charts are required for members under 21 years old.

Date:	**Form Completed By:**

1. Member's Full Name:	**2. Member's Alliance ID Number:**	**3. Member's Date of Birth** (and gestational age at birth if applicable):

4. Primary Medical Diagnosis (description and code):	**5. Secondary Medical Diagnosis** (description and code if applicable to disease-specific or specialized formula requested):

6. Current Anthropometric Measurements: (Attach growth charts of height, weight and BMI-for-age for members 2 to 21 years old. Attach growth charts of weight, length, and head circumference-for-age for members 0 to 36 months old.)

- ☐ Weight: _____ kg/ lbs
- ☐ Height: _____ cm/ in
- ☐ Body mass index (BMI): _____
- ☐ Head Circumference (if <2 years old): _____ cm
- ☐ Amount of recent weight change: _____ kg/ lbs
- ☐ Time frame of weight change: _____

7. Member's Daily Nutritional Needs:

- ☐ Kcal (Calories) _____
- ☐ Protein _____ grams
- ☐ Fluid _____ liters
- ☐ Determined by whom: _____
- ☐ On Date: _____ (member's nutritional needs must be re-assessed annually by a licensed clinician).

8. Biochemical, clinical and/or dietary indicators justifying the product request:	**9. Medical justification for member's inability to meet nutritional needs with dietary adjustments of regular or altered consistency (soft or puréed) foods:**

10. Estimated duration of need (and/or attach nutrition care plan):	**11. Prior Treatments** (failed or successful; duration and outcome):

12. Product Label Name Prescribed:	**National Drug Code (NDC)**	**Product Unit Package Size (ml or gm)**	**Product Caloric Density**	**Units per Day Needed**	**Anatomic Route of Administration**	**Primary Source of Nutrition**
a.						
b.						

If requesting disease-specific, specialized products (Diabetes, Renal or Hepatic products), please provide the following lab results:

13. For Diabetes Products: Hemoglobin A1c (HgbA1c) value measured within 6 months of this request submission.
(If HgbA1c not available, please provide results from multiple blood glucose tests indicating consistent presence of hyperglycemia.)

14. For Renal Products: Provide one of the following lab values measured within 6 months of this authorization request submission:
a. Blood Serum Potassium: _____ b. BUN: _____
c. Urine Creatinine: _____ d. Glomerular Filtration Rate (GFR):_____

15. For Hepatic Products: Results of Liver Function Tests measured within 6 months of this authorization request submission.