Request for Nutritional Products

101 West Walnut Street, Suite 123, Gardena, CA 90248-3142
Phone: 310-515-8425 / Fax: 310-515-8426

Patient's Name	Date of Birth	REP HOUSE
		Female☐ Male ☐
Medi-Cal #	**Phone#**	
Street Address	**City, Zip Code**	

Primary Diagnosis:

×

Current Weight	Current Height	Birth Weight	Birth Height

Weight Loss: lbs. within ☐ weeks ☐ months

Product	
	Refills 12
Quantity: fl oz every hr(s)	**Daily Caloric Requirements:**
	Kcal Q day:

Route of Administration:	☐ Oral
	☐ Enteral (Bolus/Continuous) For Continuous please specify ml drip per hr ml/hr
Justification for Nutritional Product:	

What is the immediate and ultimate prognosis for this patient without the us of the required product?

What alternative nutritional program has been tried with this patient?

☐ Pureed or Blended Foods ☐ Dietary Management of normal food

☐ Other (specify)

Why are other methods of providing nutrition not suitable?

The information on this form is treated as a Physician's prescription for medical care and services, therefore it must be signed by a California licensed provider in good standing.

Doctor's Name	License#	DEA#	NPI#

Address	City	Zip code

Email address:	Phone:
Signature:	**Date:**

Faxed by: **(Required by BOARD OF PHARMACY)**

I authorize the item(s) described above as medically necessary for the patient. I certified that the aforementioned is correct. I Understand that the intentional misrepresentation of diagnosis, services or medical necessity documentation herby submitted is constituted as fraud and may be subject to prosecution and/or imposition of civil monetary penalties by the Federal or State Government. I will maintain a copy of this prescription in the recipient's records to meet Medi-Cal requirements.