



Enteral Formula Request Form

Instructions

- Please fill this form out completely. Any omission(s) may delay processing of this request.
- Fax or mail this form back to:

CDPHP
Resource Coordination Department
500 Patroon Creek Blvd.
Albany, NY 12206-1057
Phone: (518) 641-4100
Fax: (518) 641-3207

PATIENT INFORMATION:

Last Name: _____ First Name: _____
 Patient ID Number: _____ Date of Birth: _____
 Patient's height (in inches): _____ Patient's weight (in pounds): _____
 Height-for-age percentile: _____ Weight-for-age percentile: _____
 If less than one year of age, has the patient been tried on a formula with added rice cereal? Yes No

PRODUCT INFORMATION:

Product(s) Requested: _____ Mode of administration: . Tube Oral
 Number of enteral formula calories prescribed per day: _____
 Approximate length of therapy: _____
 Pharmacy and Phone (if known): _____

QUESTIONS:

- Is the enteral formula prescribed for an inherited metabolic disease or an infant formula for lactose intolerance, severe food allergy or gastroesophageal reflux disease not responding to rice cereal added to formula? Yes No
 If yes, what is the diagnosis? _____
- Does this patient have a medical condition that prevents him/her from consuming normal table food or softened, mashed, pureed, or blenderized foods? Yes No
 If yes, please describe the medical condition: _____
- Has the adult patient had a significant unintentional weight loss (>5%) over the past two months or the pediatric patient had no weight or height gain in six months? Yes No
- Have alternatives such as dietary changes, instant breakfast drinks, rice cereal, etc. been tried? If so, please list these changes and the results from these changes. _____

- Please list any objective medical evidence in the patient's medical records which would support the need for enteral nutrition. For example, malnutrition documented by serum protein levels, albumin levels or hemoglobin, changes in skin or bones, or physiological disorders resulting from surgery. _____

- Please describe the treatment plan for this patient: _____

PRACTITIONER INFORMATION:

Practitioner Name: _____ Practitioner Phone #: _____
 Address: _____ Fax # (for fax notification): _____
 _____ Nurse Contact: _____ Ext: _____
 _____ Date of Request: _____