Inland Empire Health Plan

ADULT NUTRITIONAL EVALUATION FORM

TO BE COMPLETED BY PRESCRIBING PHYSICIAN ONLY
PLEASE FAX THIS FORM TO (909) 890-2058

Member Name: _____ IEHP ID #: _____

Member DOB: _____ Nutritional Supplement Requested: _____

If member needs ADULT NUTRITIONAL SUPPLEMENT due to medical conditions, please indicate one of the following and provide documentation (e.g. chart notes, nutritionist evaluation) for the specific diagnosis:

- ❑ Enteral feeding tube or transitioning from parenteral or enteral feeding tube to oral diet
- ❑ Inborn errors of metabolism, including genetic and metabolic conditions
- ❑ Intestinal malabsorption disorders
- ❑ Dysphagia and/or dysmasesis due to at least one of the following conditions: cancer in the mouth, throat, or esophagus, injury, trauma, surgery, or radiation therapy involving the head or neck, chronic neurological disorders, or severe craniofacial abnormalities
- ❑ Underweight and/or severe weight loss due to a medical condition that is being treated and/or managed with documentation that member is nutritionally at risk
- ❑ Chronic medical diagnosis and unable to meet their nutritional needs (e.g. inability to digest or absorb macronutrients such as carbohydrates, fats, protein, or have a condition that requires nutritional supplement and cannot otherwise be medically managed)
- ❑ Other: _____

Please provide ICD code(s): _____

Please explain why normal diet is not sufficient: _____
_____

Please note that adult nutritional supplement requests are covered only with medical conditions that may lead to severe malnutrition or cause extensive weight loss. Documentation is required.

1. What is your estimate of the duration of need for the requested nutritional product: _____
2. How many cans/bottles/packets will this patient require per day/week/month: _____ per _____
3. What is the patient's current **HEIGHT**: ____' ____", **WEIGHT**: _____ lbs, **BMI**: _____ kg/m^2
4. When were these measurements last recorded: _____
5. How much weight was lost: _____ lbs over what period of time: _____

Other comments: _____
_____

Physician Name:_____

Physician Signature:_____ Date: _____

10801 6th St., Suite 120, Rancho Cucamonga, CA 91730
FAX (909) 890-2058

Revised 05/15