

**REQUEST FOR ENTERAL NUTRITION PRODUCT(S)
GENETICALLY HANDICAPPED PERSONS PROGRAM**

TELEPHONE: 1-800-639-0597

FAX NUMBER: 916-327-1112

Instructions: Initial and subsequent requests for nutrition products require completion of this form. The following documents (*dated within six months of the request date*) must accompany this form:

- o Special Care Center (SCC) Physician prescription or signature on the bottom of this form
- o Current height and weight including Body Mass Index
- o SCC Registered Dietitian (RD) assessment/plan (recommended calories and/ or treatment plan)
- o SCC medical reports
- o Lab results (serum phe, plasma amino acids, etc. as indicated for the management of medical condition)

Note: Authorizations for nutrition products will be limited to 6 MONTHS

Patient name: _____ GHPP number (if known): _____

(Resident of a licensed care facility or long term care facility?) Yes ___ No ___

DOB: _____ Age: _____

Client's Special Care Center : _____

Client's SCC Physician: _____

Pharmacy vendor name: _____ Telephone #: _____

Address: _____ Fax #: _____

Nutrition product(s) requested:

NUTRITION PRODUCT NAME	NDC CODE	AMOUNT PER DAY	AMOUNT PER MONTH

This is a: Replacement Formula Elemental Formula
 Calorie Dense Product Nutrition Additive

Route of delivery: Enteral (bolus / continuous) Oral

For calorie dense products only, (check applicable boxes):

- Severe oral motor impairment and/or risk of aspiration or weight/length or height is at or below the 5th percentile
- Growth velocity is falling or at or below the 10th percentile
- Unable to maintain weight/length or height above the 5th percentile

(If there is a signed prescription, fax it with this completed form. The information below can be left blank.)

Physician name (print): _____ License #: _____

Signature: _____ Date: _____ Telephone #: _____ Fax #: _____

THIS FORM SHOULD NOT BE USED FOR MEDICAL FOODS