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.