INFANT NUTRITIONAL EVALUATION FORM

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

Member Name: ______________________IEHP ID #: ______________________PER# __________

Member DOB: __________ Nutritional Supplement Requested:______________________________

Normal Infant Formula are not covered (covered thru WIC, to find the nearest WIC local agency, please call California State WIC Branch at 1-888-942-9675; County of Riverside Health Services Agency, Department of Public Health: 800-455-4942; San Bernardino County Department of Public Health: 909-387-8301).

Please provide information below:

- ❑ If member needs Infant Formula due to medical conditions, please specify and provide documentation:
  ____
  ____
- ❑ ICD-9:____
- ❑ Hypoallergenic **infant formula** (Alimentum, Nutramigen) will only be covered if soy-protein based formula has been tried, and with documented allergic symptoms:
  ____
  ____
- ❑ This baby has tried other infant formula _________________________ before and failed.

Please note that most infant formula requests are covered up to 1 year of age unless it is medically necessary (documentation required). Weight must be less than 25% of the median weight for age.

1. What is your estimate of the duration of need for the requested nutritional product by this patient?
   ____
2. How many cans/bottles/packets will this patient require per day/week/month? _______ per _____________
3. What is the patient's current height and weight? **Height:** ___' _____" **Weight:**______lbs.
   a. Weight: ______% of median weight (weight must be less than 25% of the median weight for age)
   b. Please document this patient's most recent weight loss.
   c. How much weight lost:___________lbs. Over what period of time:_______________
4. Other comments:____

Physician Signature:__________________________________ Date: _____________________________________

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