



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 #:** _____ **PER #:** _____

Member DOB: _____ **Nutritional Supplement Requested:** _____

Please provide information below:

- If member needs ADULT NUTRITIONAL SUPPLEMENT due to medical conditions, please specify and provide documentation:

- ICD-9: _____

- Please explain why normal diet is not sufficient.

Please note that most adult nutritional supplement requests are covered only with medical conditions (documentation required) that may cause extensive weight loss. Weight must be less than 25% of the median weight for age, or BMI < 18 kg/m².

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 or BMI = _____ kg/m² (weight must be less than 75% of the median weight for age, or BMI < 18 kg/m²)

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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