

**Result of Medi-Cal Authorization Request For
Nutritional Supplement or Replacement**

Kern Health Systems has received a treatment authorization request for a nutritional supplement for the following patient.

Patient Name:

Patient ID:

1. Has patient seen Plan Dietician, or other Dietician? Date of consult _____
2. Does this patient reside in a Skilled Nursing or Intermediate Care Facility? YES _____ NO _____
3. Please submit a brief clinical resume to show the inability of this patient to maintain adequate nutrition with normal foodstuffs. (Reply on the other side.)
4. What alternative nutritional programs have been tried or considered (e.g. pureed or blenderized foods, dietary management of normal foodstuffs, etc.)? Why are possible alternatives not usable by this patient? (Reply on the other side.)
5. Is the requested item to be used as temporary or a long-term supplement to a regular diet; or as complete dietary replacement program? (Please check one).
6. Are any corrective surgical procedures planned: YES _____ NO _____
If YES, can you estimate the approximate month and year: _____
7. What is your estimate of the duration of need for the requested nutritional product by this patient
_____ weeks/months?
8. How many cans/bottles/packets will this patient require per day/week/month? _____ per _____
9. What are the immediate and ultimate prognosis for this patient, *without* use of the requested nutritional products?
Immediate prognosis:

Ultimate prognosis:

10. What are the treatment goals for this patient?

11. The diagnostic information supplied with this request indicated a malabsorption syndrome that is not further described or identified. What are the clinical and/or laboratory indications of malabsorption?

12. Other:

Reply Date: _____ Prescriber's Name _____

Prescriber's Signature _____

KHS Pharmacy Dept.

Phone# 661-664-5101

Fax# 661-664-5191 Thank you!