

QUESTIONNAIRE #10 ORAL & ENTERAL NUTRITION FORMULA

Client Name:		Medicaid ID #:	
X Length of Need:		X Height:	X BMI:
X Start Date:		x Weight:	

(For pediatric clients 2 years or under, please attach growth chart)

The information requested below is required to determine medical necessity. After you have completed this form, attach it to the completed Prior Authorization Request (PAR).

X	1) Is the participating in the Surgical Nutrition Program Study?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, questions 2 through 11 <u>do not</u> need to be completed.						
X	2) What is the complete diagnosis with complicating factors: a) List reasons why client cannot consume a regular diet to meet their nutrition needs.							
X	3) For clients age 5 and under: has client been referred to the Women, Infants, and Children (WIC) Program? a. Is the client receiving WIC services? b. If receiving formula from WIC, how many calories per day?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No						
X	4) Last 2 years weight history:	<input type="checkbox"/> Stable <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> Unknown Amount Change: <input style="width: 100px;" type="text"/>						
X	5) If the client has received supplement feeding in the past two years, what was the weight and BMI when product previously started?	Weight: <input style="width: 100px;" type="text"/> BMI: <input style="width: 100px;" type="text"/>						
X	6) Does client have difficulty chewing/swallowing: a. If yes, describe: b. Has swallow study been completed? Include results with PAR.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No						
X	7) For adults over the age of 20 , is therapy intended to serve as a protein supplement? a. If yes, what is the serum albumin level? Date of lab value? *Note: Excludes wound care clients.	<input type="checkbox"/> Yes <input type="checkbox"/> No Serum Albumin Level: <input style="width: 100px;" type="text"/> Date of Lab Value: <input style="width: 100px;" type="text"/>						
X	8) Brand formula (s) requested: a. *Note: Adjust calories per day to reflect WIC allotment.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Name: Microlipid</td> <td style="width: 30%;">Cal/day:</td> <td style="width: 40%;"></td> </tr> <tr> <td>Name:</td> <td>Cal/day:</td> <td></td> </tr> </table>	Name: Microlipid	Cal/day:		Name:	Cal/day:	
Name: Microlipid	Cal/day:							
Name:	Cal/day:							
X	9) Route of Administration:	<input type="checkbox"/> Oral <input type="checkbox"/> Tube Feeding						
X	10) Is formula:	<input type="checkbox"/> Supplement <input type="checkbox"/> Total Nutrition						
X	11) Please supply any additional information that will assist us in determining medical necessity for your request:							

Print Prescriber Name _____

Prescriber Signature X _____ Date X _____