SENIOR WHOLE HEALTH®
Simple. Secure. Independent.

58 Charles Street
Cambridge, MA 02141

Nutritional Authorization Form

Dear Dr. (PCP Name):

Patient's Name:	**Date of Birth:**	**SWH ID#:**

A request for Oral Nutritional Supplements has been received by Senior Whole Health (SWH). SWH requires (1) **prior authorization** for all oral nutrition supplements in order to determine medical necessity and (2) a **signed prescription** from the member's physician.

A member is considered to be at nutritional risk if he or she has actual, or potential for developing malnutrition, as evidenced by clinical indicators, the presence of chronic disease, or increased metabolic requirements due to impaired ability to ingest or absorb food adequately.

Please complete and FAX the information below along with a prescription to: (617) 494-5554.

I. Service Information:	
Primary diagnosis for nutritional risk:	ICD Code:
Estimated length of treatment:	Frequency:
II. Patient Questionnaire:	
Has the patient had >=10% weight loss in the last 3-6 months?	☐ Yes ☐ No
Is the patient's Body Mass Index (BMI) below 18.5kb/m2?	☐ Yes ☐ No
Does the patient have anatomic structures of GI tract that impair digestion?	☐ Yes ☐ No
Does the patient have prolonged nutrient losses due to malabsorption or short-bowel syndromes, celiac, chronic pancreatitis, Crohn's ESRD/dialysis, diabetes?	☐ Yes ☐ No
Does the patient have neurological disorders that impair swallowing/chewing?	☐ Yes ☐ No
Does the patient have increased metabolic and/or caloric needs due to prolonged fever, excessive burns, infection, trauma, draining abscess or wounds, hyperthyroidism, or illnesses that impair caloric intake or retention?	☐ Yes ☐ No
Does the patient have a diagnosis of failure to thrive or weight loss?	☐ Yes ☐ No
Is the patient receiving chemotherapy, immunosuppressants, or radiation?	☐ Yes ☐ No

Weight 6 Months Ago:	Current Weight:	Height:
Albumin Level:	Serum Protein Level:	Date of Last Exam:
Comments:		

MD Signature: _____