Physician's Order
For
Supplemental Nutrition

I. Patient Information:

Name: _____

Date of Birth: _____

Current Weight: _____

Does child eat solid food: **Yes** ☐ **No** ☐

Child on DDS Waiver: **Yes** ☐ **No** ☐

Name of Nutritional Shake:_____

Amount (bottles per day):_____

Flavor:_____

Requested Length of Issuance (6mo-1yr):_____

II. Qualifying Diagnosis:_____

_____

III.

_____ _____
Health Care Provider's name (printed) **NPI #**

_____ _____
Health Care Provider's signature **Date**

Office Phone Number:_____

Please submit to: Deana Wilson at Nutrition@ouhsc.edu or FAX 405-271-2711