RYAN WHITE PROGRAM NUTRITIONAL SUPPLEMENTS

(To be completed by the dietitian; the original of page 1 and a copy of page 2 must be maintained in the dietitian's patient file. A copy of page 1 and the original of page 2 should be forwarded to the pharmacy.)

Patient Name:_____ Date: _____

Please document patient:

Height:_____

ABW: _____ □ Lbs □ Kgs

IBW: _____ □ Lbs □ Kgs

UBW: _____ □ Lbs □ Kgs

Total Calories needed:_____g/kg/per day

Total Protein needed:_____g/kg/per day

Total Carbohydrates needed:_____g/kg/per day

Days Supply:_____

PRESCRIPTION

NOTE: 1 Serving = 2 Scoops

□ Ultra Meal Advance Protein Powder -___No. of **SERVINGS per DAY** (Only French Vanilla flavor available)

Number of Refills Authorized _____

(Number of refills authorized cannot exceed period of time for re-evaluation every 90 days by nutritionist/dietitian)

□ IgG Pure -____No. of **SERVINGS per DAY** (Only natural flavor available)

Number of Refills Authorized _____

(Number of refills authorized cannot exceed period of time for re-evaluation every 90 days by nutritionist/dietitian)

NUTRITIONAL PLAN FOR SUPPLEMENTS

I. INITIAL Consultation: Date: _____ Weight: _____

Patient assessed/instructed by Registered Dietitian/Nutritionist: **(Please check the appropriate box)**

☐ Nutritional supplements **recommended** ☐ Nutritional supplements **NOT** recommended

II. FOLLOW-UP Visit: Date:_____ Weight: _____

Patient re-assessed for progress: **(Please check the appropriate box)**

☐ Nutritional supplements **continued** ☐ Nutritional supplements **discontinued**

III. ADDITIONAL FOLLOW-UP Visit: Date: _____ Weight: _____

Patient re-assessed for progress: **(Please check the appropriate box)**

☐ Nutritional supplements **continued** ☐ Nutritional supplements **discontinued**

_____

SIGNATURE
(Registered Dietitian/Nutritionist)

_____ _____

PRINT NAME Dietitian/Nutritionist Florida License #
(Registered Dietitian/Nutritionist)

Please note: All questions should be directed to the Office of Management and Budget-Grants Coordination/Ryan White Program, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.). Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.