RYAN WHITE PROGRAM NUTRITIONAL SUPPLEMENTS REFERRAL
Physician Letter of Medical Necessity for Supplementation in ADULTS
(This form serves as a referral; the medical provider should maintain a copy of this form in the patient file.)

Date: ____________

As the licensed medical provider for____, who has a diagnosis of HIV/AIDS, it is my considered opinion that he/she requires and meets the criteria indicated below for nutritional supplements.

Patient must meet **at least two (2)** of the criteria listed below. (Dispensing limited to 4 bottles of any combination per month)

Please check all that apply:

____Current body weight < 10% IBW/UBW
____Body Mass Index (BMI) <20
____Recent illness/hospitalization that will interfere with patient's ability to consume or tolerate adequate non-supplemental nutrition
____Dysphagia and/or odonyphagia where commercial supplements are the only source of nutrition tolerated
____Inadequate living conditions or inability to buy/prepare meals
____Inability to understand and or follow nutritional recommendations
Weight loss of: ____5% of the initial/baseline weight over the past month -OR- ____7.5% over the past 3 months-OR- ____More than 10% within the last 6 months
____ Failure to gain/maintain weight in the past when following a dietary regimen to promote weight gain
____Body Cell Mass (BCM) < 40% (MALES) or BCM < 35% (FEMALE) of IBW
____Diarrhea/malabsorption with > 3 large, liquid stools/day
____Serum albumin < 3.5g/dl/Serum prealbumin (if available) <16mg/dl

I understand this patient's nutrition status must be evaluated by a Dietitian/Nutritionist no less than every 90 days.
Re-evaluation is due at ________________________________. (*Number of refills authorized cannot exceed this period of time.*)
mm/dd/yy

I believe that nutritional supplements are medically indicated in this case and I have referred this patient for a professional Nutritional Assessment at ____.
Location

Sincerely,

____ , M. D. / D.O. / ARNP / PA-C *(circle one)*
SIGNATURE
(Physician, Nurse Practitioner or Physician Assistant)

____ _____________________________

PRINT NAME Florida Medical License #

(Physician, Nurse Practitioner or Physician Assistant)

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.