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Serving Detroit, Hamtramck, Harper Woods, Highland Park and the five Grosse Pointes

Oral Nutrition Supplement (ONS) Request Form

In order for your patient to be eligible for Oral Nutrition Supplement (ONS) assistance, the Detroit Area Agency on Aging (DAAA) requires this form to be provided with an acceptable diagnosis (see below). **A prescreen must be conducted by the Information and Assistance Department followed by an initial assessment to be performed by our ONS Program Coordinator.**

A physician's prescription is no longer accepted. This form will be kept on file and must be renewed every 6 months. DAAA will provide 48 cans of ONS a month with a physician's diagnosis and signature.

- **Incomplete forms will not be processed.**
- **Older forms will not be processed.**
- **ONS must be client's sole source of nutrition.**

To receive ONS, this form must include the following information:

Participant's Name: _____

Date of Birth: _____ **Telephone Number:** _____

Address: _____

Please select one: _____ **Ensure** _____ **Glucerna**

Please select one: _____ **8 weeks** _____ **6 months**

Determination of Need:

Under my care, this patient has been identified as unable to consume pureed or mechanically soft food. This patient has been unable to maintain weight due to their diagnosis, therefore, _____ **requires an oral nutrition supplement.**
(patient name)

I understand that the State of Michigan Department of Health and Human Services does not recognize oral nutrition supplements (i.e., Ensure and Glucerna) as a full meal but I am ordering it to assist my patient to maintain his/her nutritional intake.

Physician's signature (REQUIRED): _____ **Date:** _____

-over-

Please circle one of the eligible diagnoses below: Diagnoses with asterisk must be accompanied with a secondary diagnosis.

A. (B20) AIDS
B. (C32.9) MALIGNANT NEOPLASM of LARYNX (CANCER)
C. (E46) ***UNSPECIFIED PROTEIN-CALORIE MALNUTRITION**
D. (E84.9) CYSTIC FYBROSIS
E. (E88.81) METABOLIC SYNDROME
F. (K21.9) GASTRO-ESOPHAGEAL REFLUX DISEASE
G. (K50.90) CHROHN'S DISEASE
H. (R13.10) SWALLOWING OR MASTICATION DIFFICULTY SECONDARY TO ANY ONE OF THE FOLLOWING:
   1) Actively being treated for cancer in throat, oral cavity, or neck; or
   2) Injury surgery or current/prior radiation therapy to neck; or
   3) Chronic neurological disorders (e.g., Stroke); or
   4) Severe craniofacial abnormality
I. (R63.0) ***ANOREXIA**
J. (R63.4) ***ABNORMAL WEIGHT LOSS**
K. (Z91.01) SEVERE FOOD ALLERGIES WHICH IF LEFT UNTREATED WILL CAUSE MALNOURISHMENT
L. (Z93.1) PATIENT IS ON A FEEDING TUBE

Please sign and Fax this form to:

ATTN: ONS Program Coordinator
Fax Number: 313.446.4459

If you have any questions, please contact the ONS Program Coordinator at 313.446.4444, ext. 5266.

Thank you for your cooperation.

/th
Nutrition/010924/Oral Nutrition Supplement Request Form

Revised 3/24