Detroit Area Agency on Aging
The Senior Solution

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

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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 eligible diagnosis (see below). **A pre-screen must be conducted by the Information and Assistance Department followed by an initial assessment to be performed by our ONS Program Assessor.**

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; however I am recommending it to assist my patient to maintain his/her nutritional intake. As a reminder, this program is supplemental only and provides 1/3 DRI per day and is not intended as a sole source of nutrient.

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

- **Incomplete forms will not be processed.**
- **Outdated or forms issued before_____ or after _____.**
- **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 for chemo patients only:

Under my care, this patient has been identified as unable to consume adequate nutrients from food due to their diagnosis. Clients with chemo will only be offered supplements during treatments. Dates must be provided.

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

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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)
Treatment Dates: _____ TO _____

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 Assessor
Fax Number: 313.446.4459

If you have any questions, please contact the ONS Program Assessor at 313.446.4444.

Thank you for your cooperation.

/th
Nutrition/010924/Oral Nutrition Supplement Request Form

Revised 3/25