KIDNEY FOUNDATION OF OHIO, INC.

2018 Nutritional Supplement Order Form

This form should be completed and attached to all initial applications for nutritional supplements. If approved, nutritional supplement refills or changes should be faxed **directly** to ExactCare Pharmacy at **216-369-2201**.

Clinic:_____ Patient Name: _____

Contact:_____ Patient Phone:_____

Clinic Phone:_____ Patient Date of Birth:_____

Physician's Name _____ Allergies : _____

Products: Please check box

Ensure Plus 24 Per Case	**Glucerna Shake 24 Per Case**
☐ Chocolate ☐ Vanilla ☐ Strawberry ☐ Butter Pecan	☐ Chocolate ☐ Vanilla ☐ Strawberry ☐ Butter Pecan
Boost Plus 24 Per Case	**Boost Glucose Control 24 Per Case**
☐ Chocolate ☐ Vanilla	☐ Chocolate ☐ Vanilla ☐ Strawberry
Boost Energy 24 Per Case	**Boost High Protein 24 Per Case**
☐ Chocolate ☐ Vanilla	☐ Chocolate ☐ Vanilla ☐ Strawberry
Nepro 24 Per Case	**Resource Breeze 27 Per Case**
☐ Mixed Berry ☐ Vanilla ☐ Butter Pecan	☐ Orange ☐ Peach ☐ Wild Berry ☐ Variety Pack
Liquacel Protein 960 ML Bottle	**Zone Bar (Solid) 12 Bars Per Case**
☐ Peach Mango ☐ Grape ☐ Orange ☐ Lemonade	☐ Fudge Graham ☐ Strawberry Yogurt

Other (Fill in name and flavor) :_____

Refills:_____ Cans Per Day:_____

**By signing this document, I am authorizing ExactCare Pharmacy to refill the prescriptions for a period of 12 months unless otherwise noted. A staff member from ExactCare Pharmacy will contact the social worker if a grant renewal is needed.*

Physician Signature: _____ Date:_____