



## 2021 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**

<b>Ensure Plus      24 Per Case</b> <input type="checkbox"/> Chocolate <input type="checkbox"/> Vanilla <input type="checkbox"/> Strawberry <input type="checkbox"/> Butter Pecan	<b>Glucerna Shake      24 Per Case</b> <input type="checkbox"/> Chocolate <input type="checkbox"/> Vanilla <input type="checkbox"/> Strawberry <input type="checkbox"/> Butter Pecan
<b>Boost Plus      24 Per Case</b> <input type="checkbox"/> Chocolate <input type="checkbox"/> Vanilla <input type="checkbox"/> Strawberry	<b>Boost Glucose Control      24 Per Case</b> <input type="checkbox"/> Chocolate <input type="checkbox"/> Vanilla <input type="checkbox"/> Strawberry
<b>Boost Energy      24 Per Case</b> <input type="checkbox"/> Chocolate <input type="checkbox"/> Strawberry	<b>Boost High Protein      24 Per Case</b> <input type="checkbox"/> Chocolate <input type="checkbox"/> Vanilla <input type="checkbox"/> Strawberry
<b>Nepro      24 Per Case</b> <input type="checkbox"/> Mixed Berry <input type="checkbox"/> Vanilla <input type="checkbox"/> Butter Pecan	<b>Resource Breeze      27 Per Case</b> <input type="checkbox"/> Orange <input type="checkbox"/> Peach <input type="checkbox"/> Wild Berry
<b>Liquacel Protein 960 ML Bottle</b> <input type="checkbox"/> Peach Mango <input type="checkbox"/> Grape <input type="checkbox"/> Orange	<b>Zone Bar (Solid)      12 Bars Per Case</b> <input type="checkbox"/> Fudge Graham

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: \_\_\_\_\_