



2023 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 <input type="checkbox"/> Chocolate <input type="checkbox"/> Vanilla <input type="checkbox"/> Strawberry	Glucerna Shake 24 Per Case <input type="checkbox"/> Vanilla <input type="checkbox"/> Strawberry <input type="checkbox"/> Butter Pecan
Boost Plus 24 Per Case <input type="checkbox"/> Chocolate <input type="checkbox"/> Vanilla <input type="checkbox"/> Strawberry	Boost Glucose Control 24 Per Case <input type="checkbox"/> Chocolate <input type="checkbox"/> Vanilla
Boost Energy 24 Per Case <input type="checkbox"/> Chocolate <input type="checkbox"/> Strawberry	Boost High Protein 24 Per Case <input type="checkbox"/> Chocolate <input type="checkbox"/> Strawberry
Nepro 24 Per Case <input type="checkbox"/> Mixed Berry <input type="checkbox"/> Vanilla <input type="checkbox"/> Butter Pecan	Boost Breeze (Clear) 27 Per Case <input type="checkbox"/> Orange <input type="checkbox"/> Peach <input type="checkbox"/> Wild Berry
Liquacel Protein 960 ML Bottle <input type="checkbox"/> Peach Mango <input type="checkbox"/> Grape <input type="checkbox"/> Orange	Zone Bar (Solid) 12 Bars Per Case <input type="checkbox"/> Fudge Graham <input type="checkbox"/> Strawberry Yogurt
Kate Farms Renal Support 1.8 12 per case	<input type="checkbox"/> Vanilla

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: _____