KIDNEY FOUNDATION OF OHIO, INC.

2024 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. All products are subject to availability.

Ensure Plus **24 Per Case**	**Glucerna Shake** **24 Per Case**
☐ Chocolate ☐ Vanilla ☐ Strawberry	☐ Vanilla ☐ Strawberry ☐ Butter Pecan
Boost Plus **24 Per Case**	**Boost Glucose Control** **24 Per Case**
☐ Chocolate ☐ Vanilla ☐ Strawberry	☐ Chocolate ☐ Vanilla
Boost Energy **24 Per Case**	**Boost High Protein** **24 Per Case**
☐ Chocolate ☐ Strawberry	☐ Chocolate ☐ Strawberry
Nepro **24 Per Case**	**Boost Breeze (Clear)** **27 Per Case**
☐ Mixed Berry ☐ Vanilla ☐ Butter Pecan	☐ Orange ☐ Peach ☐ Wild Berry
Liquacel Protein 960 ML Bottle	**Zone Bar (Solid)** **12 Bars Per Case**
☐ Peach Mango ☐ Grape ☐ Orange	☐ Fudge Graham ☐ Strawberry Yogurt
Kate Farms Renal Support 1.8 **12 per case**	☐ 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: _____