NUTRITIONAL SUPPLEMENT REQUEST FORM

TO: _____ **FAX #:** _____ **DATE:** _____

FROM: ST. LOUIS PEREGRINE SOCIETY 314-781-6775/FAX 314-781-6494

The Peregrine Society is happy to partner with you by providing nutritional supplements to cancer patients under your care. To qualify for this program, your patients' need must be associated with a current cancer diagnosis and/or ongoing cancer treatments or related issues. **Please complete this form and fax back to our office at 314-781-6494.**

Request made by: _____ Date: _____

Healthcare Agency Name: _____

Phone #: _____ Fax #: _____ E-mail Address: _____

PATIENT INFORMATION

Please complete all of the following information:

Patient Name: _____ DOB: _____

Patient Address: _____
Street

_____
City Zipcode

Patient Phone(s): _____

Is Patient Diabetic? _____ Is Patient Enrolled in Hospice? _____

NUTRITIONAL SUPPLEMENT NEED CRITERIA

Oncologist Name: _____ Phone #: _____

Cancer Dx: _____ Date of Dx: _____

Is patient undergoing radiation or chemotherapy treatments: _____

If so, from: _____ until: _____

Excessive weight loss due to cancer dx: _____

Other - please explain reason for request (i.e. - cancer surgery, esophageal scarring, etc.):

_____

_____

Supplement Requested: (Circle One) Boost Boost Plus Boost Glucose Control(vanilla only) IsoSource

Cirlce flavor(s) requested (Boost & Boost Plus only): Vanilla Chocolate Strawberry
If flavor is not indicated, vanilla will be sent.

Length of time supplement will be needed: 3 mos 6 mos

Comments: _____

Dr.'s Signature: _____ **Date:** _____

St. Louis Peregrine Society, caring for cancer patients since 1949. www.peregrinesoc.org