L.A. Care HEALTH PLAN
For All of L.A.

L.A. Care Medically Tailored Home Delivered Meals – Diet Prescription

Return form to L.A. Care: Fax 213-438-4866 / Email: Mltss@lacare.org (send via secured email only)

SECTION I: Member information

Member/ Patient information

Member Name: _____

Member DOB: _____

Medical ID#: _____

Member Address: _____

Member Telephone #: _____

SECTION II: Clinical information

Diagnosis: _____

_____

Medically Tailored Meal Type Request:	**List of Medications:** **Information can be provided via facesheet, medication list and MD Prescription*	**Pertinent Labs: *May attach labs**
☐ **Diabetes Suitable** ☐ **Gluten Free** ☐ **Heart Healthy** ☐ **Low Sodium** ☐ **Pureed** ☐ **Renal** ☐ **Vegetarian**	• _____ • _____ • _____ • _____ • _____ • _____	A1c_____Date:_____ FBG_____Date:_____ eGFR_____Date:_____ Chol_____Date:_____ TG_____Date:_____

Referral for Medical Nutrition Therapy consult with Registered Dietitian: ☐ **Yes** ☐**No**

Additional Comments: _____

Physician Address:	
Physician Phone#:	**Physician Fax#:**
Professional License Number:	**Licensing Authority:**
Physician Signature: **Date:**	

By signing this form, I certify that I am licensed in the state of California and all information provided above is correct.

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