RAMSEY COUNTY

160 East Kellogg Boulevard
Saint Paul, MN 55101 – Phone # 651-266-4496

Disability Services
CDCS

Verification of Prescribed Diet

This form should be completed by the MN Health Care Provider doctor prescribing the special diet. The form is used in conjunction with Alternative Treatment form the MHCP is completing for the use of Medical Assistance Long Term Care waiver dollars to fund the special diet

Participant First and Last Name: _____**PMI Number** _____

Evaluation of Special Diet

Prescribed Diet(s):
If multiple diets are listed, do they overlap with respect to their dietary components in any way? Please mark YES, NO or N/A.

	Overlap?		
Anti Dumping	☐Yes	☐No	☐N/A
Gluten Free	☐Yes	☐No	☐N/A
Controlled protein (40-60 grams/requires special products)	☐Yes	☐No	☐N/A
Controlled protein (less than 40 grams/requires special products)	☐Yes	☐No	☐N/A
High Protein (minimum 80 grams per day)	☐Yes	☐No	☐N/A
High Residue	☐Yes	☐No	☐N/A
Hypoglycemic	☐Yes	☐No	☐N/A
Ketogenic	☐Yes	☐No	☐N/A
Lactose Free	☐Yes	☐No	☐N/A
Low Cholesterol	☐Yes	☐No	☐N/A
Pregnancy and Lactation	☐Yes	☐No	☐N/A

Length of the prescribed diet(s) (print or type)
_____

Condition Diet is Treating (print or type)

_____

_____

_____

_____ _____
Physician's Name (print or type) **Date**

_____ _____
Physican's Signature **Date**