

Thickener Prescription Form supplied by:



1) Patient Name (First & Last): _____ DOB: ____ / ____ / ____

Patient Telephone: _____ Secondary Telephone: _____

3) Primary Diagnosis (select all applicable):

- R13.11 Dysphagia, oral phase R13.12 Dysphagia, oropharyngeal phase
- R13.13 Dysphagia, pharyngeal phase K21.9 Gastro-esophageal reflux without esophagitis
- Other: _____

4) Secondary Diagnosis (Please select or provide appropriate Secondary Diagnosis)

- ICD10 R62.51 failure to thrive Other: _____

5) Rx for Product and Indications for Use (**select one**) and Daily Liquid Required (**please complete**):

INFANTS: GELMIX Infant Thickener for Breast Milk & Formula (B4100)

- SLIGHTLY thick/thin nectar: 2 scoops/ 1 stick= 1 tsp or 2.4g of Gelmix per 4 fluid oz
- MILDLY thick/nectar: 2 scoops/ 1 stick= 1 tsp or 2.4g of Gelmix per 3 fluid oz
- MODERATELY thick/honey: 2 scoops / 1 stick pack= 1 tsp or 2.4g of Gelmix per 2 fluid oz

Daily Feedings:

#	oz.
---	-----

 x

#

 feedings =

#

 / oz.daily liquid

PEDIATRICS: PURATHICK Natural Thickener for Pediatrics (B4100)

- SLIGHTLY thick/thin nectar: 1 scoop/ 1 stick pack= 1 tsp or 2.4g of Purathick per 8 fluid oz
- MILDLY thick/nectar: 1 scoop/ 1 stick pack= 1 tsp or 2.4g of Purathick per 6 fluid oz
- MODERATELY thick/honey: 1 scoop/ 1 stick pack= 1 tsp or 2.4g of Purathick per 4 fluid oz
- EXTREMELY thick/pudding: 1 scoop/ 1 stick pack= 1 tsp or 2.4g of Purathick per 2 fluid oz

Daily Feedings:

#	oz.
---	-----

 x

#

 feedings =

#

 / oz.daily liquid

6) Length of Need/ Refills (select one): 3 months 6 months Other: _____

I certify with my signature that I am the physician named below. The information contained on this Written Order is true and complete to the best of my knowledge. This patient was evaluated by me and treated for the condition as stated above. The patient's medical record accurately contains documentation to support medical need and utilization of the Thickener prescribed by me. This order is reasonable and necessary for the diagnosis and treatment of the patient's illness. The patient's caregiver has been trained on the proper use of the Thickener and is capable of following these instructions. A copy of this signed order will be maintained on file as part of the patient's medical record and made available to Medicare, Medicaid, or other Insurance for post payment review or audits.

Physician Name: _____ Ph: (____) ____ - ____ Medicaid #: _____

Physician Signature: X _____ NPI # _____

Fax completed form along with the documents listed below to: **(877) 748-1985**

- **Patient Face Sheet** (containing current demographics and insurance)
- **Medical Records** (stating diagnosis, medical need for thickener, and documenting prior interventions)
- **SPL Evaluation** (documenting swallowing disorder and liquid consistency recommendations)
- **Therapy/ Hospital Notes** (documenting aspiration, unsafe swallowing, weight loss, dehydration, or hospitalization risk)

For further assistance, please contact your Gelmix/ Purathick Thickener Specialist at (877) 748-1987.

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