Health Care Provider Assessment Form

In order for Tulane University Dining Services to best serve all students, we ask that you complete this form describing the student’s dietary restrictions or special dietary needs. This form must be completed by a healthcare professional only. Once this form is completed, please provide a copy to the student so they may submit it as part of their meal plan petition.

Student Name: ____________________________________________________________

Person providing this assessment: __________________________________________

(please circle one or list other)

MD  Nurse  Other: _______________________________________________________

State of Licensure: ___________________________ License Number:______________

Phone Number: ___________________________ Fax: __________________________

Date of initial appointment: ___________ Date of most recent appointment: ___________

Total number of times you have seen the student: __________________________

Diagnostic Impression (including ICD 10 or DSM 5 code when applicable): ___________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Prognosis: __________________________________________________________________

Nutrition Prescription: __________________________________________________________________

By signing where indicated below I am representing to Tulane University that my response to each question listed above is true, complete, and accurate to the best of my knowledge and belief, this constitutes my best professional judgement and opinion, and that the Patient did not prepare or draft this response for my signature.

Signature: ___________________________ Date: ___________________________