Tulane University
DINING SERVICES
by sodexo

Health Care Provider Assessment Form

Instructions: ***Please complete the form below to assist Tulane University Dining Services in providing appropriate food or meal plan modifications. Merely stating that the individual should be released from the meal plan is insufficient.***

Student Name:	**Student DOB:**
Person Providing Assessment: ☐MD ☐ Nurse ☐ Registered Dietitian ☐Mental Health Professional	
Health Care Professional Name:	**Office Phone Number:**
State of Licensure:	**Licensure Number:**
Date of Most Recent Appointment:	**Number of Appointments:**

Medical Conditions (please check all that apply):

Food allergy to:	☐Milk ☐Egg ☐Fish ☐Peanut ☐Shellfish ☐ Soy ☐Tree nut ☐Wheat ☐Other (please specify):	☐Celiac Disease
Medical Condition (please specify using ICD 10 or DSM 5 codes):		
Diagnostic instruments utilized to reach above diagnosis	☐Lab results ☐Allergy testing ☐ROME III Criteria ☐Other, please specify	☐Endoscopy ☐Bowel Biopsy ☐Oral Food Challenge
Other diagnostic information (may include weight/growth history, relevant psychosocial or medical history, etc.)		

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Brief explanation of why the student's medical condition affects their ability to participate in the meal plan:

Diet Prescription: Foods Omitted and Substitutions	
Please list a specific diet prescription and/or food(s) to be omitted and food(s) that may be substituted. You may attach additional documentation if necessary.	
Omitted Foods	**Substitutions**

Indicate length of time special diet must be followed:			
☐**Ongoing**	☐**Temporary**	**Start Date:**	**End Date:**
☐**I certify that the above named student requires special dietary modifications as described above, due to the student's food allergies and/or medical conditions.**			
Health Care Professional Signature:		**Date:**	

Meal Plan Petition Guidelines for Documentation

While formal documentation is required for consideration of meal plan release at Tulane University, the staff of Tulane University Dining Services recognizes that each individual experiences barriers to access differently. Therefore, we encourage students requesting meal plan releases to meet with Tulane Dining Services staff to discuss their unique situation.

Tulane seeks to afford all students an equal opportunity to participate in the University's meal services program. Such participation includes the opportunity to dine with others. Dining Services (including the Campus Dietitian and Executive Chef) will make a determination on whether a medically restrictive diet can be reasonably accommodated by the dining program upon review of a physician's diagnosis or prescriptive diet.

To meet this requirement, Tulane University Dining Services must be provided documentation meeting the following criteria on the Health Care Assessment form:

1. **<u>Qualified Evaluator:</u>** Professionals conducting assessments and making recommendations for appropriate accommodations must be qualified to do so (e.g., physician, psychiatrist, allergist, gastroenterologist). The name, title, and professional credentials of the evaluator, including license or certification number, should be clearly stated on the Health Care Provider Assessment Form. The evaluator may not be a member of the student's family.
2. **<u>Current Documentation:</u>** Documentation should be current and related to the individual's special dietary need. The following guidelines are in place; however, documentation that exceeds these time parameters may be considered.
    a. Food allergies, intolerances-documented in the past 12 months
    b. Celiac disease-documented in the past 3-4 years
    c. Procedure-documented after procedure if it is reason for special dietary need
3. **<u>Comprehensive Documentation:</u>** Documentation should be thorough, giving a full picture of the individual, not simply a diagnosis. It might include:
    a. A diagnostic interview including:
        i. Historical information detailing the evolution of the special dietary need
        ii. Relevant psychosocial, medical, and medication history
        iii. Weight and growth history
        iv. History of accommodation
        v. Evidence of current special dietary need
    b. Diagnostic instruments appropriate to the diagnosis are recommended. These may include lab results, allergy testing, motility and gastrointestinal tests, or bowel biopsies.
    c. A clear diagnosis must be rendered. Diagnostic codes from the DSM-5 or the ICD-10 should be utilized.
    d. Description of current treatments, therapeutic techniques, assistive devices, medication, etc.
    e. The evaluator should make specific recommendations for accommodations including a diet prescription and specific foods that must be avoided for medical reasons.

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL HEALTH INFORMATION

TUCH must obtain a written authorization from a patient or their Personal Representative prior to releasing Confidential Health Information, unless a legal exception applies. This form must be fully and completely filled out to be valid. A reasonable copying and handling charge may be charged for this request pursuant to La. R.S. 40:1165.1. All requests should be sent to: **Campus Health, Tulane University, 6823 St. Charles Ave., Bldg. 92, New Orleans, LA 70118** or faxed to **504-865-5083.**

PATIENT AND RECIPIENT'S INFORMATION

I hereby authorize The Administrators of the Tulane Educational Fund d/b/a Tulane University and Tulane University Campus Health to release Confidential Health Information from the records of:

Patient's Information		**TO - Recipient's Information:**	
Name:	______________________	Name:	______________________
DOB (MM-DD-YYYY):	______________________	Address:	______________________
Splash ID:	______________________	Phone:	______________________
Phone:	______________________	FAX:	______________________

PURPOSE OF DISCLOSURE

☐ Treatment ☐ Personal ☐ Legal ☐ Academic

SPECIFIC TREATMENT PERIODS

Specific treatment date or time period for which the information is requested:

☐ Single treatment date of ______________________.

☐ Period of treatment from ______________________ to ______________________.

☐ Any and all treatment encounters to date.

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

Specific description of information to be used or disclosed (*Check all that apply*):

___ Progress Notes
___ Doctor's Orders
___ Nurse's Notes
___ Lab Reports
___ CAPS Mental Health Records
___ Results of STD/STI Testing
___ Billing Records
___ Immunization Records
___ Prescription/Medication Records
___ All Campus Health Treatment and Billing Records.
___ CAPS Psychotherapy Notes (*If checked, all other records must be requested in a separate authorization.*)
___ Other (Please Describe): ____

I hereby consent to release my HIV test results: _________ (Initial) I have a right to refuse to release my HIV test results. , except where release is authorized by law without my consent.

I understand that :

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing. **This authorization, and in copy thereof, will be deemed revoked once the requested disclosure is made. Subsequent authorizations must be executed for each requested disclosure.**
4. If the receiver is not a health care provider the information may no longer be protected by federal privacy regulations.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee.
6. I may have a copy of this form after I sign it.

SIGNATURES

I have read the above and authorize the disclosure of the Confidential Health Information as stated.

Signature of Patient/Personal Representative:	Date:
Print Name of Patient's Personal Representative (*Authority document must be attached*):	Relationship to Patient