METABOLIC FORMULAS MEDICAL REFERRAL FORM

All fields must be completed.
Please fax the finished form to 877-295-2775 or email to AN-HCP-REFERRAL@abbott.com

Patient Name: _____

Patient Date of Birth: _____

Patient Shipping Address:

Street: _____

City: _____ State: _____ Zip Code: _____

Parent/Caregiver Name (if patient is under 18): _____

Parent/Caregiver Phone Number: _____

Parent/Caregiver Email Address: _____

Product:

☐ Calcilo XD®	☐ Cyclinex®-1	☐ Glutarex®-1	☐ Hominex®-1
☐ I-Valex®-1	☐ Ketonex®-1	☐ Phenex®-1	☐ Pro-Phree®
☐ Propimex®-1	☐ ProViMin®	☐ RCF®	☐ Tyrex®-1

Amount of Product: _____ cases per month*,†

Duration of Use: ☐ **3 months** ***or*** ☐ **6 months** ***or*** ☐ **12 months**

Physician Name: _____

Physician Phone Number: _____

DEA or NPI Number: _____

Physician Signature: _____ Date: _____

By submitting this form and your patient's information, you represent and warrant that you've obtained any necessary consents or authorizations from your patient to disclose their information to Abbott Nutrition and its contracted third parties.

* **Number of cans per case and amount of product per can:** Level-1 products and Pro-Phree: six 400g cans; Calcilo XD: six 352g cans; ProViMin: six 150g cans; RCF: twelve 13-fl-oz cans.

† Only one (1) case will be provided free of charge.