Children and Youth with Special Health Care Needs (CYSHCN)

PRESCRIPTION

For the provision of Formula and/or Nutritional Supplements

As a CYSHCN program requirement this form needs to be completed and returned to our office with the Physician's ***signature.***

Patient's Name: _____

Date of Birth: _____

Name of Formula(s)/Supplement(s) Prescribed: _____

Prescribed daily amount +/or special instructions/requests:

_____

Length of use:

☐ 1 month ☐ 3 months ☐ 6 months ☐ 12 months

Practitioner's Signature (REQUIRED): _____ **Date** _____

Medical office address:_____

Office phone number: _____

Practitioner S.C. License Number: _____

DHEC 4006 (3/2019)

South Carolina Children and Youth with Special Health Care Needs

Special Formula Prescription

(Instructions for completing DHEC 4006)

Purpose: To use when issuing a prescription for CYSHCN approved special formula.

Explanation: This form is completed by the healthcare professional licensed to write medical prescriptions under state law.

Item-by-item Instructions:

Patient's Name: Enter name of the patient.

Date of Birth: Enter patient date of birth.

Name of Formula/supplement prescribed: Enter exact name of formula or supplement.

Prescribed daily amount +/special instructions: Enter amount: ounces or cans, packets per day. Enter any special instructions or comments.

Length of use: Place a check in the box of the time period desired.

Practitioner's Signature: Provider enters signature and credentials.

Date: Enter date prescription written.

Medical Office Address: Enter office name, address, city, zip code.

Office Phone Number: Enter office phone number .