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:**<br>☐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<br>☐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<br>☐Allergy testing<br>☐ROME III Criteria<br>☐Other, please specify | ☐Endoscopy<br>☐Bowel Biopsy<br>☐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:** | |

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**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. **Qualified Evaluator:** 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. **Current Documentation:** 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. **Comprehensive Documentation:** 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.

Campus Health
TULANE UNIVERSITY

# CONSENT TO THE VERBAL INTRA-UNIVERSITY SHARING OF CONFIDENTIAL HEALTH INFORMATION

It is the policy of Tulane University Campus Health ("TUCH") to share information within Tulane University, to include sharing by verbal discussion, to facilitate the delivery of essential campus resources and support services. In order to share this information at the direction of a student, TUCH requires a signed consent form. Please be aware that disclosure of Confidential Health Information without a student's consent is allowed but under only very limited exceptions. Tulane University, to include TUCH leadership, believes that these exceptions should be construed in a balanced manner protecting student health, safety, and privacy interests. TUCH Staff and Tulane University Officials will always take care to consider the impact of such sharing, and will only disclose the minimum amount of Confidential Health Information necessary for the intended purpose. Tulane University gives great weight to the reasonable expectations of students that their Confidential Health Information generally will not be shared, or will be shared only in the rarest of circumstances, and only to further important purposes, such as assuring campus and student safety. This form must be fully and completely filled out to be valid.

I, the patient listed below, hereby authorize The Administrators of the Tulane Educational Fund d/b/a Tulane University and Tulane University Campus Health to share my Confidential Health Information through verbal communication with office(s) designated below.

## PATIENT INFORMATION

Name: _____

DOB (MM-DD-YYYY): _____ Splash ID: _____

Phone: _____

## PURPOSE OF DISCLOSURE

☐ Coordination of Care
☐ Academic
☐ Case Management

## SPECIFIC TREATMENT DATE(S)

☐ Single treatment date of (MM/DD/YR)_____.
☐ Period from (MM/DD/YY)_____ to (MM/DD/YY) _____.
☐ Any and all treatment encounters to date.

## AUTHORIZED DURATION OF COMMUNICATION

☐ Single date of (MM/DD/YR)_____.
☐ Period from (MM/DD/YR)_____ to (MM/DD/YR)_____.
☐ Current academic year, July 1 to June 30

## DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

Specific description of information to be used or disclosed. (*Check only those that apply and describe below.)*

☐ Attendance
☐ Diagnosis
☐ Treatment recommendations
☐ Prognosis
☐ Medications
☐ Safety

*Description*:

## SHARE WITH RECIPIENT OFFICE

☐ Student Resources and Support Services
☐ Case Management and Victim Support Services (CMVSS)
☐ Campus Health
☐ Health Center for Student Care
☐ CAPS for Counseling Services
☐ The Well for Health Promotion
☐ Tulane Emergency Medical Services
☐ Department of Athletics
☐ Dining Services
☐ Housing and Residence Life
☐ ROTC
☐ Title IX
☐ Other: _____

## PATIENT SIGNATURE

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

Signature of Patient: _____ Date: _____

## TREATMENT PROVIDER and DEPARTMENT

Name: _____

☐ Health Center ☐ CAPS ☐ The Well