UNIVERSITY OF ST. THOMAS DINING
PHYSICIAN FORM

Full Name _____

Local Address _____

_____

Telephone Number_____ Best times to call (1)_____ (2)_____

UST E-Mail Address_____

UST Meal Plan _____ UST Student Year _____

FOR PHYSICIAN'S USE ONLY – Please check all, that apply

- ☐ Dairy Allergy
- ☐ Lactose Intolerance
- ☐ Wheat Allergy
- ☐ Gluten Intolerance
- ☐ Celiac Disease
- ☐ Egg Allergy
- ☐ Soy Allergy
- ☐ Peanut Allergy
- ☐ Tree Nut Allergy
- ☐ Fish Allergy
- ☐ Shellfish Allergy
- ☐ Corn Allergy
- ☐ Diabetes
- ☐ Diverticular Disease
- ☐ Crohn's Disease
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Short Bowel Syndrome
- ☐ Oral Surgery

Other, please note_____

☐ _____

What are the patient's possible reactions to the above-indicated allergen(s) or conditions?

What are the medically necessary accommodations to help manage the health of the patient?

Indicate the length of time a special diet will be required:

☐ Ongoing ☐ Temporarily from _____ until _____

Is the patient currently under a continuing physician's care? ☐ Yes ☐ No

Date of last visit _____

Printed Name and Title of Physician:_____

Physician Address:_____

_____

Physician Telephone Number: _____ _____

Physician's Signature and Date

When completed, please return to Andrea Cossetta.

(Fax) 651-962-6058 (Phone) 651-962-6075 amcossetta@stthomas.edu

FOR UST DINING USE ONLY

The *Physician Form* was received on _____

Student appointment was set for _____

Notes: