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CONTINUUM CONNECT ENTERAL NUTRITION ORDER FORM

Please attach face sheet w/ patient demographics & insurance info
Please attach lab work, clinical notes and/or any other relevant documentation

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____ Gender: Male Female
Language Pref.: English Spanish Other: _____ Emergency Contact Name/Phone Number: _____

DIAGNOSIS

Primary Diagnosis ICD-10 Code: _____ Secondary Diagnosis ICD-10 Code: _____

Order Date: ____/____/____ Length of Need: _____ months (numeric form only)

SUPPLIES:

Feeding Pump: (choose one)
 Covidien Joey Pump Feeding Bags: 500ml 1000ml Quantity: 30p/m Other _____
 EnteraLite Infinity Pump Feeding Bags: 500ml 1200ml Quantity: 30p/m Other _____

IV Pole
 Gravity Bags: Quantity _____ Hydrocolloid 4x4: Quantity _____ Split Gauze: 2x2 4x4 Quantity _____
 Tape: 1" 2" Plastic (waterproof) Cloth (waterproof) Paper Medipore: 2" 4"
 Syringes Size: 60cc 12cc 10cc 5cc Other _____
Quantity: _____ Quantity: _____ Quantity: _____ Quantity: _____ Quantity: _____

TUBES

Mic-Key Button Kit: FR _____ CM _____ Quantity: 1 every 3 months Other _____
 AMT Mini-One Button: FR _____ CM _____ Quantity: 1 every 3 months Other _____
 Extension Sets: Manufacturer Ref#: _____ Quantity: 4p/m Other _____
 NG Tube: FR _____ CM _____ Quantity: 3 p/m Other _____
Choose One: Weighted Non-Weighted Choose One: Stylet No Stylet

FORMULA:

Formula Type _____ 24 Hour
 Standard Caloric Intake Daytime _____cc every _____hrs
 Other: _____Calories per oz. Nighttime _____cc every _____hrs

Formula Type _____ 24 Hour
 Standard Caloric Intake Daytime _____cc every _____hrs
 Other: _____Calories per oz. Nighttime _____cc every _____hrs

Thickener: _____ Consistency: Honey Nectar
Amount of fluid per day _____mls

Additional Feeding or Order Notes:

REFERRAL INFORMATION

Ref #: _____

Practice Name: _____ Fax: _____
Office Address: _____ Email: _____
Phone: _____ Preferred Method of Contact? Phone Fax Email
Contact Person: _____

Physician Name: _____ NPI#: _____ Phone: (____) _____ - _____ Ext. _____
Physician Signature: _____ Date: ____/____/____

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.