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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: \_\_\_\_\_ Patient cannot accept deliveries on the following days?
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Mon Tues Wed Thurs Fri Sat

DIAGNOSIS

Primary Diagnosis

ICD-10 Code: \_\_\_\_\_

Secondary Diagnosis

ICD-10 Code: \_\_\_\_\_

NG TUBE:

DISPENSE

- Type: \_\_\_\_\_ French Size: \_\_\_\_\_ in.
 Tape:  1"  2"  3"
 Medipore:  Plastic (waterproof)  Cloth (waterproof)  Paper
 2"  4"
 Duoderm
 Split Gauze
 PH Strips
 Other

GT REPLACEMENT:

DISPENSE

- Type: \_\_\_\_\_ Size: \_\_\_\_\_
 Extension Sets

METHOD:

DISPENSE

- Bolus feeds by feeding pump \_\_\_\_\_ cc every \_\_\_\_\_ hour(s)
 Continuous feeds \_\_\_\_\_ cc every \_\_\_\_\_ hour(s)
 Dispense feeding pumps, bags and IV Pole
 Bolus feeds by gravity \_\_\_\_\_ cc every \_\_\_\_\_ hour(s)
 60 CC Syringes  Cath-tipped  Luerlock
 Syringes \_\_\_\_\_ cc \_\_\_\_\_ per month
 Flush: After feeds or meds.  Syringe  Bag \_\_\_\_\_ cc

FORMULA:

- Type: \_\_\_\_\_
 Additives: \_\_\_\_\_

Order Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Length of Need: \_\_\_\_\_ months

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.

Assignment of Benefits: I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_