Continuum
a CHC Solutions Company

PHONE: 1.800.344.1550 FAX: 1.844.317.9379
EMAIL: orders@chcsolutions.com

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: _____

Height: _____ Weight:_____

Patient cannot accept deliveries on the following days?
☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

DIAGNOSIS

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

NG TUBE:		DISPENSE
☐ Type: _____ French	Size: _____in.	
☐ Tape: / Medipore:	☐ 1" ☐ 2" ☐ 3" ☐ 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: _____/_____/_____