HealthSource
a CHC Solutions Company

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

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