CHC SOLUTIONS, INC.

FAX: 1.888.308.9763
EMAIL: nutriorders@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: ______________ Emergency Contact Name/Phone Number: ______________________

DIAGNOSIS

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

Order Date: _____/_____/_____ **No. of Refills:** ☐ **6 months** ☐ **12 Months** ☐ **Other:** __________

SUPPLIES:

Feeding Pump: (choose one)	Pump	Feeding Bags	Quantity
	☐ 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 Quantity:_______ ☐ 12cc Quantity:_______ ☐ 10cc Quantity:_______ ☐ 5cc Quantity:_______ ☐ Other____________ 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, 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.

Call 1.800.220.5262 or visit www.chcsolutions.com for additional information.

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