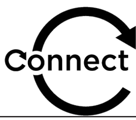

FAX: 1.888.248.2026
EMAIL: connect@chcsolutions.com

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)	
☐ 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 1.888.248.1975 or visit www.connectchc.com for additional information.

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