CHC SOLUTIONS, INC.

FAX: 1.877.299.7606
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
ICD-10 Code: _____

Secondary Diagnosis
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 ☐ 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

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.