

ENTERAL PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:



Patient Name:	Date of Birth:		
Address:			
Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:
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Allergies:

Enteral Tube Placement Status

Tube placed – date: _____ Tube placement pending – anticipated date: _____

Type of feeding tube placed or anticipated type to be placed:

<input type="checkbox"/> NG (nasogastric) tube	<input type="checkbox"/> G-tube (gastrostomy or PEG)	<input type="checkbox"/> G/J-tube
<input type="checkbox"/> NJ (nasojunal) tube	<input type="checkbox"/> J-tube (jejunostomy or PEJ)	<input type="checkbox"/> Other: _____

Type of connection: ENFit Legacy

Prescription (Select One of the Following Options)

Option Care Health dietitian to assess patient's needs and recommend initial feeding plan, additional free water flushes, and advancement to goal.

Enteral nutrition as follows:

Feeding Method:

Syringe (bolus) Gravity Pump

Formula Name:

Equivalent formulations may be substituted where clinically appropriate.
Check here if formulation substitution is **not** permitted – .

Feeding Plan:

Please indicate amount and frequency.

Additional Free Water Flushes:

Please indicate amount and frequency for tube patency and patient hydration.

Anticipated duration of therapy: _____ year(s) months weeks

Skilled nurse to assess, teach, and train self-administration of enteral feeding to patient and/or caregiver.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State:	Zip:	Office Contact:

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