ENTERAL PRESCRIBER ORDER FORM

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

option care health

Patient Name:			**Date of Birth:**	
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description: | **ICD-10 Code:**

Allergies:

Enteral Tube Placement Status

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

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

☐ NG (nasogastric) tube ☐ G-tube (gastrostomy or PEG) ☐ G/J-tube

☐ NJ (nasojejunal) tube ☐ J-tube (jejunostomy or PEJ) ☐ 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:**	

