Detailed Written Order

Patient Name: _____

Address: _____

DOB: _____ Height: _____ Weight: _____

Diagnosis: _____

Start Date: _____ Length of Need (#in months): _____ 1-99 (99= lifetime)

Please support this order with clinical notes that include a face to face, diagnosis, and the need for enteral supplies.

Indicate if criteria A, B, and C are met.

☐ A - Enteral nutrition is being provided via feeding tube.

☐ B - Patient requires enteral feedings to maintain weight and strength.

☐ C - Enteral feedings are required for 3 months or longer.

Prescribed Enteral Formula

Nutrient: _____ ml/day: _____ and/or Calories/day: _____

Additional Enteral Formula

Nutrient: _____ ml/day: _____ and/or Calories/day: _____

Route of Administration - Please Select One

☐ **Enteral Feeding Pump** - Pump Rate: _____ ml per hour (B4035 Pump Kit, E0776 IV Pole. B9002 Feeding Pump, Flush Syringes)

(Support the need for a pump with documentation. i.e. gravity is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, rate less than 100ml/hour, blood glucose fluctiation.)

☐ **Enteral Feeding Syringe** - (B4034 Supply Kit/Syringes)

☐ **Enteral Feeding Gravity** - (B4036 Gravity Supply Kit/E0776 IV Pole/Flush Syringe)

Practitioner name: _____

Address: _____ Phone: _____ NPI: _____

Date of Face-to-face visit prior to ordering this respiratory item: _____ Practitioner signature: _____ Date: _____

fax to: 847-573-1909