emerging HEALTH

Enteral nutrition order

Referral information

Referral name	Phone	Fax

Patient information

Patient name		Date of birth	Gender
Height	Weight	Allergies	
Patient address			
City	State	ZIP	
Insurance provider		Insurance ID#	
Following physician		Phone	Fax
ICD-10 Primary diagnosis		ICD-10 Secondary diagnosis	

Order information

Order date	Therapy start date	Length of need (in months)

☐ **Dietitian consult:** Request Dietitian to complete nutrition assessment for home tube feeding order recommendations (Please fax clinical documentation with request.)

Formula order

Formula name	Volume: _____ mL/day **OR** _____ cartons/day	Calories: _____ /day _____ /month
Formula name	Volume: _____ mL/day **OR** _____ cartons/day	Calories: _____ /day _____ /month
Modular name	Amount: _____ /day	Calories: _____ /day _____ /month
Free water flush		

Supply order

Days per week administered: ☐ 7 ☐ 6 ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Route of administration: ☐ G Tube ☐ J Tube ☐ GJ Tube ☐ NG Tube ☐ NJ Tube ☐ Other: _____ **Tube type:** ☐ Legacy ☐ ENFit

Bolus: ☐ B4034 Feeding supply kit: Syringe fed (1 per day, 30 per month)
_____ mL/feeding, _____ times/day **OR** _____ cartons/feeding, _____ times/day

Gravity: ☐ B4036 Feeding supply kit: Gravity fed (1 per day, 30 per month)
☐ E0776 IV Pole (1 unit)
_____ mL/feeding, _____ times/day **OR** _____ cartons/feeding, _____ times/day

Pump: ☐ B4035 Feeding supply kit: Pump fed (1 per day, 30 per month)
☐ E0776 IV Pole (1 unit)
☐ B9002 Pump (1 unit)
Administration rate: _____ mL/hr x _____ hrs/day

Feeding tube supplies

Replacement feeding tube:

NG Tube: ☐ B4081 With stylet (4/month) ☐ B4082 Without stylet (4/month)
Brand: _____ French size (Fr): _____ Length (cm): _____ **Tube type:** ☐ Legacy ☐ ENFit

G Tube: ☐ B4088 Low-profile button (1 EA/3 months) ☐ B4087 Standard balloon tube (1 EA/3 months)
Brand: _____ French size (Fr): _____ Length (cm): _____ **Tube type:** ☐ Legacy ☐ ENFit

Extension sets: ☐ B9998 (4/month) Brand: _____ Length: ☐ 12" ☐ 24" **Tube type:** ☐ Legacy ☐ ENFit
Type: ☐ Continuous/right angle ☐ Bolus/straight

Additional supplies: _____

Physician authorization: I hereby certify that the above supplies are medically necessary and are authorized by me. The patient is under my care and requires the services outlined above. (Stamped signature and date are not acceptable. Please initial and date any manual changes on this form.)

Physician signature	Print name	Date	NPI

Fax completed forms to 877-290-2050. Questions? Call us at 877-290-2040.