Enteral Nutrition New Order Form

Hearts Enteral, LLC©
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*REQUIRED FIELD

This is not a prescription

Referral Contact Name_____ Phone_____ Email_____

PATIENT INFORMATION

Patient Name (full name) *_____ Date of Birth*____/____/_____
Gender ☐ M ☐ F Height*_____ Weight*_____ Food Allergies: ☐ None ☐ _____

Primary Phone*_____ Secondary Phone_____ Email_____
Delivery Address* Street _____ **City**_____ **State**_____ **Zip** _____

Primary Insurance Provider:_____ Insurance ph.:_____
Insurance ID#_____ Group # _____
Secondary Insurance YES ☐ NO ☐ (if yes, please attach a copy of any secondary insurance card with this form)

Physician_____ Phone_____
Clinic_____ Fax _____
Registered Dietitian _____ Phone:_____ Email _____

ENTERAL FORMULA ORDER

1 Order Date* ____/____/_____ ☐ Initial start ☐ Revised/changed

2 Diagnosis ICD-10* _____ _____ _____ _____
3 HCPCS Code(s)* _____ _____ _____ _____
4 Length of Need*_____ months ☐ lifetime (99 months)

5 Route* ☐ Oral ☐ G-tube ☐ J-tube ☐ NJ-tube Other _____

6 **Formula Name*** _____
Formula Total: Volume_____(gm/mL) per day,_____cans per day*,_____
cans per month*,____Total calories*,_____ per day____per month(units) _____

7 **Formula Name*** _____
Formula Total: Volume (gm/mL) per day,___cans per day*,_____
cans per month *,_____Total calories*_____per day, _____per month(units)_____

ENTERAL SUPPLIES ORDER

1. Order Date*_____
2. Diagnosis ICD-10* _____ _____ _____
3. HCPCS Code(s) _____

Enteral Products: (check what applies)

Bolus Feed: _____, **G-tube**: _____ **J-tube** _____ **NJ- tube**_____ **Other**_____

New Pump (add type of pump) _____, **Existing Pump (add type of pump)** _____

Pump IV Pole _____, Qty #_____Portable pump backpack_____ Qty#_____

EN-Fit end syringes: ML_____ Qty per month _____ Feeding bag: Qty per month_____

- **MIC-KEY Gastrostomy Tube**: French_____, CM_____, Qty per month #_____
  MIC EN Fit extension set size: _____, Qty per month _____
- **Mini-ONE Gastrostomy Tube**: French_____, CM_____, Qty per month #_____
  Mini-One En-Fit extension set size: _____, Qty Per month#_____

Other supplies: _____
_____
_____

IMPORTANT PLEASE READ*** Please attach a copy of your ☐prescription(s), ☐insurance card(s), ☐letter of medical necessity (LMN), ☐ recent progress notes with nutrition assessment.**

☐ **Additional Info:** _____

If you have questions, please contact our customer service team at Hearts Enteral (973) 706-6704.By signing below, I authorize the use of this document as an pre-order and NOT a physical prescription. I understand that any medical records support the medical need for the item(s) prescribed. I also understand and agree to Hearts Enteral HIPAA Notice of Privacy Practices.

Print prescriber name_____ **NPI ***_____**Tax ID#:** _____

Prescriber signature* _____**Date***_____/____/_____

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