



Enteral Nutrition New Order Form

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***REQUIRED FIELD**

This is not a prescription & not attended to use as a Rx for orders.

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* ____/____/____

