NUTRICAREUSA

COMPASSIONATE CARE, COMPLETE NUTRITION

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PATIENT INFORMATION

Patient Name* _____ Date of Birth*____ /____ /_____

Gender*: ☐ M ☐ F Height*_____ Weight*_____ Food Allergies: ☐ None ☐ _____

Primary Phone*_____ Secondary Phone _____

Delivery Address*: Street _____ City _____ State _____ Zip _____

Insurance Provider _____ Insurance ID # _____ (or submit copy of face sheet)

Primary Care Physician _____ Phone _____

Home Health Agency _____ Phone _____

ENTERAL ORDER

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

2 Diagnosis ICD-10* _____ _____ _____ _____

3 Length of Need* ____ months ☐ lifetime (99 months)

4 Route* ☐ G-tube ☐ J-tube ☐ NG-tube ☐ NJ-tube Other _____ | ☐ ENFit Tube Connection

5 Formula Name* _____ or equivalent formula ☐ No formula substitutions

6 Formula Total* Volume _____ mL per day **OR** _____ cartons per day (Enter volume mL or cartons, not both)
Total calories from formula *_____ per day, *_____ per month Additional info _____

7 Formula Name _____ or equivalent formula ☐ No formula substitutions

8 Formula Total Volume _____ mL per day **OR** _____ cartons per day (Enter volume mL or cartons, not both)
Total calories from formula _____ per day, _____ per month Additional info _____

9 Modular Name _____ Daily schedule _____ Total calories _____ per day, _____ per month

10 Method*: Enter method, feeding schedule, AND supply kit to be dispensed

☐ **Syringe Bolus**	☐ **Gravity-Drip Bag**	☐ **Pump Infusion with Bag**
Volume _____ mL/feeding, ____ times/day	Volume _____ mL/feeding, ____ times/day	Rate _____ mL/hr, for ____ hours/day
OR _____ cartons/feeding, ____ times/day	**OR** _____ cartons/feeding, ____ times/day	Additional info _____
☐ Syringe, 30/month (B4034)	☐ Gravity Bag, 30/month (B4036)	☐ Pump Bag, 30/month (B4035)
	☐ IV Pole (E0776)	☐ IV Pole (E0776) ☐ Pump (B9002)

11 Water Flush Total Volume _____ mL per day
Daily Schedule Volume _____ mL water before and after feedings by syringe
Volume _____ mL water, _____ times/day by syringe **OR** every _____ hours by syringe
Rate of _____ mL/hr water every _____ hour(s) by pump when running

FEEDING TUBE SUPPLY REPLACEMENT AT HOME

Extension Sets Low Profile-Button brand _____, compatible extension sets 4/month (B9998)
Extension Set type: ☐ Continuous (right angle) ☐ Bolus (straight) Length: ☐ 12" ☐ 24"

G-tube Replacement Feeding Tube brand _____ French size (Fr) _____ Stoma length (cm) _____
☐ Low Profile-Button, 1 ea/3 months (B4088) ☐ Standard Profile Balloon, 1 ea/3 months (B4087)

NG-tube Replacement Feeding Tube brand _____ or equivalent French size (Fr) _____ Tube length (cm) _____
☐ With Stylet, 3 ea/3 months (B4081) ☐ Without Stylet, 3 ea/3 months (B4082) ☐ Weighted ☐ Non-weighted

Other Supplies _____

If you have questions, please contact an enteral nutrition specialist at (337) 236-4377. By signing below, I authorize the use of this document as a dispensing prescription. I understand the final decision with respect to ordering a tube feeding product for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my medical records support the medical need for the items prescribed.

Print prescriber name* _____ **NPI #*** _____

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