



# Enteral Nutrition Standard Written Order

Phone: 800-223-4376  
Fax: 800-355-1029

Referral Date:  
Clinic Contact:  
Phone:

Email:

To ensure timely processing, please complete and submit with insurance cards (front & back), demographics, clinical notes

Patient Detail		
Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Parent or Legal Guardian, where applicable:		
Address:	City:	State: Zip Code:
Phone:	Email Address:	
Allergies:	Diagnosis:	
Insurance Detail		
<input type="checkbox"/> Information attached (including front & back of insurance cards)		
Primary Plan Name:	Subscriber Name:	DOB:
ID #:	Group #:	Phone:
Prescriber Detail		
Prescriber Name:	NPI:	License #:
Address:		
Phone:	Fax:	Email:
Enteral Order		
1. Formula or Modular Name (Nutritionally equivalent substitutions allowed)	Volume Per Day	Calories per Day
2. Route:	<input type="checkbox"/> G-tube <input type="checkbox"/> J-tube <input type="checkbox"/> NG-tube <input type="checkbox"/> Other _____	
3. Method of Administration (Select one below plus pole and pump if needed)		
<input type="checkbox"/> Syringe Bolus - 30 syringes/ month (B4034/S9343) _____ mL/feeding _____ times/day	<input type="checkbox"/> Gravity Bag - 30 bags/month (B4036/S9341) <input type="checkbox"/> IV Pole (E0776) _____ mL/feeding _____ times/day	<input type="checkbox"/> Pump Infusion - 30 bags/month (B4035/S9342) <input type="checkbox"/> IV Pole (E0776) <input type="checkbox"/> Pump (B9002) _____ mL/hr for _____ hours/day
4. Water Flush: _____ ml per day	5. Length of Need	<input type="checkbox"/> Refill monthly for 12 months <input type="checkbox"/> Other _____
Replacement Tubing Supplies		
<input type="checkbox"/> Extension Sets	Low Profile-Button Brand _____ 4/month (B9998)	
<input type="checkbox"/> G-tube Replacement	1. Feeding Tube Brand _____ French Size (Fr) _____ Stoma Length (cm) _____	
	2. <input type="checkbox"/> Low Profile-Button, 1 ea/3 months (B4088) <input type="checkbox"/> Standard Profile Ballon, 1ea/3 months (B4087)	
<input type="checkbox"/> NG-tube Replacement	1. Feeding Tube brand _____ French Size (Fr) _____ Tube Length (cm) _____	
	2. <input type="checkbox"/> w/ stylet, 3 ea/3months (B4081) <input type="checkbox"/> Without Stylet, 3 ea/3 months (B4082)	

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. Pentec Health may contact this patient for purposes of completing the referral process.

Prescriber Signature:

Date:

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