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: ☐ M ☐ F	DOB:	
Parent or Legal Guardian, where applicable:			
Address:	City:	State:	Zip Code:
Phone:	Email Address:		
Allergies:	Diagnosis:		

Insurance Detail

☐ 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:	☐ G-tube ☐ J-tube ☐ NG-tube ☐ Other_____

3. Method of Administration (Select one below plus pole and pump if needed)

☐ Syringe Bolus - 30 syringes/ month (B4034/S9343) _____mL/feeding _____times/day	☐ Gravity Bag - 30 bags/month (B4036/S9341) ☐ IV Pole (E0776) _____mL/feeding _____times/day	☐ Pump Infusion - 30 bags/month (B4035/S9342) ☐ IV Pole (E0776) ☐ Pump (B9002) _____mL/hr for _____hours/day

4. Water Flush:	_____ml per day	5. Length of Need	☐Refill monthly for 12 months ☐ Other_____

Replacement Tubing Supplies

☐ Extension Sets	Low Profile-Button Brand_____ 4/month (B9998)
☐ G-tube Replacement	1.Feeding Tube Brand_____ French Size (Fr)_____ Stoma Length (cm)_____ 2. ☐Low Profile-Button, 1 ea/3 months (B4088) ☐Standard Profile Ballon, 1ea/3 months (B4087)
☐ NG-tube Replacement	1. Feeding Tube brand_____ French Size (Fr)_____ Tube Length (cm)_____ 2. ☐w/ stylet, 3 ea/3months (B4081) ☐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:**