

ENTERAL PRESCRIBER ORDER FORM				
Patient Name:			Date of Birth:	
Address:				
Phone:		Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kg
Clinical Information				
Primary Diagnosis Description:			ICD-10 Code:	
Allergies:				
Enteral Tube Placement Status				
<input type="checkbox"/> Tube placed – date: _____ <input type="checkbox"/> Tube placement pending – anticipated date: _____ Type of feeding tube placed or anticipated type to be placed: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> NG (nasogastric) tube <input type="checkbox"/> NJ (nasojejunal) tube </div> <div> <input type="checkbox"/> G-tube (gastrostomy or PEG) <input type="checkbox"/> J-tube (jejunostomy or PEJ) </div> <div> <input type="checkbox"/> G/J-tube <input type="checkbox"/> Other: _____ </div> </div> Type of connection: <input type="checkbox"/> ENFit <input type="checkbox"/> Legacy _____				
Prescription (Select One of the Following Options)				
<input type="checkbox"/> Option Care Health dietitian to assess patient's needs and recommend initial feeding plan, additional free water flushes, and advancement to goal.				
<input type="checkbox"/> Enteral nutrition as follows:				
Feeding Method: <input type="checkbox"/> Syringe (bolus) <input type="checkbox"/> Gravity <input type="checkbox"/> Pump				
Formula Name: _____ Equivalent formulations may be substituted where clinically appropriate. Check here if formulation substitution is <u>not</u> permitted – <input type="checkbox"/> .				
Feeding Plan: <u>Please indicate amount and frequency.</u>				
Additional Free Water Flushes: <u>Please indicate amount and frequency for tube patency and patient hydration.</u>				
Anticipated duration of therapy: _____ <input type="checkbox"/> year(s) <input type="checkbox"/> months <input type="checkbox"/> weeks <i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>				
Prescriber Signature: _____			Date: _____	
Prescriber Information				
Prescriber Name:		Phone:		Fax:
Address:		NPI:		
City, State:	Zip:	Office Contact:		
Fax completed form, insurance information, and clinical documentation to:				
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