

ENTERAL PRESCRIBER ORDER FORM					
Patient Name:			Date of Birth:		Gender:
Address:					
Phone:		Height:	☐ inches ☐ cm	Weight:	☐ lbs ☐ kg
Clinical Information					
Primary Diagnosis Description:				ICD-10 Code:	
Allergies:					
Enteral Tube Placement Status					
☐ Tube placed – Date: _____			☐ Tube placement pending – Anticipated date: _____		
Type of feeding tube placed or anticipated type to be placed:					
☐ NG (nasogastric) tube		☐ G-tube (gastrostomy or PEG)		☐ G/J-tube	
☐ NJ (nasojunal) tube		☐ J-tube (jejunostomy or PEJ)		☐ Other: _____	
Type of connection: ☐ ENFit ☐ Legacy _____					
Prescription (Select One of the Following Options)					
☐ Option Care Health dietitian to assess patient's needs and recommend initial feeding plan, additional free water flushes, and advancement to goal.					
☐ Enteral nutrition as follows:					
Feeding Method: ☐ Syringe (bolus) ☐ Gravity ☐ Pump					
Formula Name: _____ Equivalent formulations may be substituted where clinically appropriate. Check here if formulation substitution is <u>not</u> permitted – ☐ .					
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: _____ ☐ year(s) ☐ months ☐ 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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