

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 ***not*** permitted – .**Feeding Plan:*****Please indicate amount and frequency.*****Additional Free Water Flushes:*****Please indicate amount and frequency for tube patency and patient hydration.***Anticipated duration of therapy: _____ year(s) months weeks*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*

Prescriber Signature: _____ Date: _____

Prescriber Information

Prescriber Name: _____

Phone: _____

Fax: _____

Address: _____

NPI: _____

City, State: _____

Zip: _____

Office Contact: _____

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