ENTERAL NUTRITION & SUPPLIES STANDARD WRITTEN ORDER

PROCARE HOME MEDICAL

Please fax to:
Anchorage (907) 274-0773
Fairbanks (907) 458-8914
Soldotna (907) 260-3757
Wasilla (907) 357-7883
or email to:
dme@procarehm.com

Patient Name, Address, Telephone & Insurance ID#:

Phone: **Ins ID#:**

Patient DOB: **Sex:** **(M/F)**

Please refer to Enteral coverage criteria sheet for all required documentation.

ENTERAL:

Date of Last Visit: _____

Diagnosis and Code: _____ Patient Height:_____in. Weight: _____ lbs.

Length of Need (# of months):_____ 1-99 (99=life) Order Date: _____

Formula:

Formula Type #1: _____ Substitution Allowed Calories per day:_____

Formula Type #2: _____ Substitution Allowed Calories per day:_____

Deliver Method: ☐ Oral (i.e. drinking) ☐ Syringe (Bolus) ☐ Gravity ☐ Pump

Pump Settings: Feed Rate(mL/hour): _____ Flush (mL/hour): _____ Total Volume to be fed: _____

Gravity: _____ mLs/hr _____ hours or _____ times per day

Syringe: _____ mLs/hr _____ hours or _____ times per day

Tube Type: ☐ Gastrostomy (G) Tube 1 every 3 months

☐ Jejunostomy (J) Tube 1 every 3 months

☐ Nasogastric (NG) Tube 1 every month

☐ ENFit

Size:_____ ☐ Standard ☐ Low Profile

Supplies:

☐ Feeding Pump with IV Pole

☐ Syringes 30/mo *may select multiple sizes* ☐ 20mL ☐ 60mL

☐ Gauze (each) *select one size* ☐ 2x2 70/mo ☐ 4x4 50/mo

☐ Tape 1/month ☐ Waterproof ☐ Non-Waterproof

☐ Extension Sets 4/mo

☐ Feeding Bags 30/month

☐ IV Pole*(required for Gravity Method)*

☐ Feeding Pump Backpack

☐ Other: _____

PROVIDER CERTIFICATION:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

Provider's Signature: _____ Date: _____ NPI: _____

Provider's Name: _____ Telephone: _____