promptcare™

Fax to: 800-889-0862

Enteral Nutrition Physician's Order

Patient Name:	**Order Start Date:**	
Date of Birth:	**Phone #:** ☐ Mobile ☐ Home	
Address:	**Email:**	
City:	**State, Zip:**	
Primary Insurance / Insurance ID:	**Secondary Insurance / Insurance ID:**	
Diagnosis 1:	**Diagnosis 2:**	
Diagnosis 3:	**Current Height:** ☐ IN ☐ CM	**Current Weight:** ☐ LB ☐ KG

Formula ☐ Substitution Permissible	**Calories Per Day**	**Total Daily Volume** ☐ ML ☐ OZ

Feeding Method

☐ Bolus / Syringe (30 Enteral Bolus Supply Kits, 60cc Syringes, Gauze/Tape or Duoderm/Tegaderm)

☐ Gravity Method (IV Pole, and 30 Enteral Gravity Supply Kits, 60cc Syringes, Gauze/Tape or Duoderm/Tegaderm)
☐ Gravity via Bag ☐ Gravity via Syringe

☐ Pump-Assisted (IV Pole, Enteral Pump, 30 Enteral Pump Supply Kits, 30 Feeding Bags, 60cc Syringes, Gauze/Tape or Duoderm/Tegaderm)

Feed Rate: _____ ml/hr x _____ hours

Justification for a Pump:
- ☐ Slow administration rate less than 100ml/hr
- ☐ Jejunostomy tube used for feeding
- ☐ Circulatory Overload
- ☐ other:_____
- ☐ Reflux or aspiration with gravity feeds
- ☐ Severe diarrhea unless feeding infused slowly
- ☐ Dumping Syndrome
- ☐ Blood Glucose Fluctuations

Type Feeding Tube: ☐Enfit ☐Non-Enfit
☐ NG ____FR ____inches ☐Weighted ☐Stylet ☐Other: _____ Qty/mo: ___
☐ MIC ____ FR _____cc balloon
☐ Mickey Button _____FR _____cm length
☐ Mini-One _____ FR _____cm length
☐ Surgically placed PEG
☐ J-tube
☐ GJ-tube: Brand _____
☐ Extension Sets ___/mo TYPE: ☐12inch ☐24 inch ☐Bolus ☐Y-adaptor
☐ Other: _____

Prescriber:	Phone:	
Address:	Fax:	
City, State, Zip:	NPI#:	
Physician's signature:	**Length of need:** # of Months _____ (99 = lifetime)	Date:

Please fax with clinical documentation (H&P, Nutrition Notes, etc.) to **800-889-0862**