

Date:		Order Type: <input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Clarification	
Provider Information			
Provider Phone Number:		Provider Fax Number:	
Patient Information			
Patient Name:		Patient DOB:	

Clinical Information			
Patient Height:		Patient Weight	
ICD-10 Diagnosis Code(s):			
Feeding Tube Type:		<input type="checkbox"/> Gastrostomy (G-Tube) <input type="checkbox"/> PEG Tube <input type="checkbox"/> Gastrojejunostomy (G-J Tube) <input type="checkbox"/> Jejunostomy (J-Tube) <input type="checkbox"/> Nasogastric Tube (NG) <input type="checkbox"/> Nasoduodenal/Nasojejunal Tube (ND/NJ) <input type="checkbox"/> Other: _____	
ENFit Feeding Tube?		Oral Diet:	
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Length of Need (1-12 Months or 99 Lifetime):			

Eligibility Information			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will the enteral nutrition be administered via feeding tube? (i.e. gastrostomy tube, jejunostomy tube, nasogastric tube)?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the enteral nutrition required to provide sufficient nutrients to maintain weight and overall health?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is adequate nutrition intake <u>not possible</u> through dietary adjustment and/or oral supplements?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a diagnosis reflecting an impairment of the Gastrointestinal Tract?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the impairment of long and indefinite duration (at least 3 months)?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is supporting documentation provided with referral? (i.e. H&P, Surgical Note, Dietitian's Note, Speech Therapy Note, Swallow Study)		
If any of the above questions were answered "No", patient may not qualify for enteral nutrition by their insurance.			

Order Information			
Formula Name:		Equivalent Formula Allowed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cans Per Day:		Calories Per Day:	
Administration:		<input type="checkbox"/> Bolus <input type="checkbox"/> Gravity <input type="checkbox"/> Pump Instructions (Bolus Amount, Advancement, etc.): _____	
Supplies Needed:		<input type="checkbox"/> Syringes (B4304) _____ per Month <input type="checkbox"/> Gravity Bags (B4306) _____ per Month <input type="checkbox"/> Pump (B9002) x1 <input type="checkbox"/> IV Pole (E0776) x1 <input type="checkbox"/> Feeding Set (Flush and Feed, B4035) _____ per Month <input type="checkbox"/> Feeding Set (Feed only, B4035) _____ per Month <input type="checkbox"/> MIC-KEY Bolus Extension Set _____ per month <input type="checkbox"/> MIC-KEY Continuous Extension Set _____ per month <input type="checkbox"/> Other: _____	
Modular (Optional):		Name: _____ Amount Per Day: _____ Administration Instructions: _____	