SSMHealth at Home

Enteral Nutrition Rx / Order Form

Patient Name: ______________________________ DOB: ______________

Patient Address: ______________________________

Diagnosis: ______________ Height: __________ Weight: __________ Target Weight: __________

Please select or list your answers below.

1. Does the patient have a permanent (3 months or greater) non-function or disease of the structures that normally permit food to reach or be absorbed by the small bowel? ❑ Yes ❑ No
2. Is there documentation in the medical record that supports the patient having permanent disease of the gastrointestinal tract causing malabsorption severe enough to prevent maintenance of weight and strength commensurate with the patient's overall health status? ❑ Yes ❑ No
3. Total calories required per day: ______________
4. Total calories from enteral product per day: ______________
5. Total calories from other ingested food/liquid per day: ______________
6. Estimated length of need (months): ______________ 1-99 (99 = lifetime)
7. Does the patient have any documented food allergies/intolerances? ❑ Yes ❑ No
   If yes, please list: ______________________________

Please select or list your answers below.

1. Delivery site of formula: ❑ ORAL ❑ NG TUBE ❑ G TUBE ❑ J TUBE
2. Method of administration: ❑ PUMP ❑ GRAVITY ❑ BOLUS (syringe) ❑ N/A
3. If pump is used, what is the administration rate? __________ ml/hour x __________

Products/Equipment Needed

1. Enteral product(s): ______________________________
   (please note flavor preference if applicable)
2. # of cans/packets needed per day/month: ______________
3. Additional equipment needs:
   Syringes (list size): ______________
   Mic-Key feeding tube: French size: ________ Length: ________ Extension tubing: ❑ Yes ❑ No
   Specific port types: ______________
   Other: ______________________________
4. Is an IV pole needed? ❑ Yes ❑ No

Some insurances may require additional information. We will contact you if additional information is required.

Please sign, date, and return this form with supporting medical records.

Provider Name: ______________________________ Date: ______________

Provider Signature: ______________________________ NPI#: ______________

Clinic Name: ______________________________ Phone: ______________

Address: ______________________________

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