

# Enteral Order Form

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_

Fax: \_\_\_\_\_

MRN: \_\_\_\_\_

Duration of Need: \_\_\_\_\_ Months (max 12months)

**Demographics and Nutrition / Clinical documentation needs to be faxed with order**

**Primary Care Provider if not the ordering Provider:** \_\_\_\_\_

**Formula:**

1) Type: \_\_\_\_\_

Amount per day: \_\_\_ml/\_\_\_per day **OR** \_\_\_cans/\_\_\_per day

2) Type: \_\_\_\_\_

Amount per day: \_\_\_ml/\_\_\_per day **OR** \_\_\_cans/\_\_\_per day

**Thickner** (Feeding Eval or OPM Evaluation will need to be faxed along with order)

Type:  Hormel Thick and Easy  Simply Thick Gel  Other: \_\_\_\_\_

Consistency:  Honey  Syrup  Nectar

Mixing Instruction: \_\_\_\_\_

Amount of Fluid per day: \_\_\_\_\_mls

**Enteral Equipment / Supplies**

Feeding Pump Rate: \_\_\_\_\_mls / hr

Feeding Bags: Size:  500mls  1000mls  1200mls

Dispense: 30 per month

Extension Sets:  Continuous  Bolus

Dispense: 4 per month

Syringes: Size:  5 ml  10 ml  20ml  60ml

Dispense: 4 per month

**Feeding Tubes**

Mickey Button \_\_\_Fr \_\_\_cm Dispense: 1 every 3 months

Mini One/AMT \_\_\_Fr \_\_\_cm Dispense: 1 every 3 months

NG Tube \_\_\_Fr \_\_\_cm Dispense: 2 -3 every month

**Dressings:**

G-tube:  Mepilex 6x6  Mepilex Lite 6x6  Mepilex AG 6x6  Polymem 4x4  Other: \_\_\_\_\_

Dispense: 12 per month

NG:  Duoderm Thin 4x4 Dispense: 2-3 sheets / month

Tegaderm 2x2 Dispense 12 per month

Hypafix Tape Dispense 1 box per month prn

**Diagnosis**

Primary Diagnosis

Secondary Diagnosis

Aspiration

Cerebral Palsy 343.9

Other: \_\_\_\_\_

Dysphagia 787.20

Chromosomal Disorder 758.9

Other: \_\_\_\_\_

Feeding Difficulty 783.3

Developmental Delay 315.9

Other: \_\_\_\_\_

GERD 530.81

Encephalopathy 348.3

Other: \_\_\_\_\_

G-tube Status V44.0

HIE 348.1

Provider Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Provider Printed Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_/\_\_\_ - \_\_\_\_\_ Fax: \_\_\_/\_\_\_ - \_\_\_\_\_