MEMORIAL HERMANN

Enteral Nutrition Referral Form

Phone: 281-784-7550 Fax: 281-784-7545

Date:		**Order Type:** ☐ Initial ☐ Revised ☐ 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:	☐ Gastrostomy (G-Tube) ☐ PEG Tube ☐ Gastrojejunostomy (G-J Tube) ☐ Jejunostomy (J-Tube) ☐ Nasogastric Tube (NG) ☐ Nasoduodenal/Nasojejunal Tube (ND/NJ) ☐ Other: _____		
ENFit Feeding Tube?	☐ Yes ☐ No	**Oral Diet:**	
Length of Need (1-12 Months or 99 Lifetime):			

Eligibility Information		
☐ Yes	☐ No	Will the enteral nutrition be administered via feeding tube? (i.e. gastrostomy tube, jejunostomy tube, nasogastric tube)?
☐ Yes	☐ No	Is the enteral nutrition required to provide sufficient nutrients to maintain weight and overall health?
☐ Yes	☐ No	Is adequate nutrition intake not possible through dietary adjustment and/or oral supplements?
☐ Yes	☐ No	Does the patient have a diagnosis reflecting an impairment of the Gastrointestinal Tract?
☐ Yes	☐ No	Is the impairment of long and indefinite duration (at least 3 months)?
☐ Yes	☐ 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?**	☐ Yes ☐ No
Cans Per Day:		**Calories Per Day:**	
Administration:	☐ Bolus ☐ Gravity ☐ Pump Instructions (Bolus Amount, Advancement, etc.): _____		
Supplies Needed:	☐ Syringes (B4304) _____ per Month ☐ Gravity Bags (B4306) _____ per Month ☐ Pump (B9002) x1 ☐ IV Pole (E0776) x1 ☐ Feeding Set (Flush and Feed, B4035) _____ per Month ☐ Feeding Set (Feed only, B4035) _____ per Month ☐ MIC-KEY Bolus Extension Set _____ per month ☐ MIC-KEY Continuous Extension Set _____ per month ☐ Other: _____		
Modular (Optional):	Name: _____ Amount Per Day: _____ Administration Instructions: _____		

☐ I, referring provider, attest that I have discussed this referral with the patient, and the patient has provided consent to the sharing of their demographic and contact information with Memorial Hermann or its affiliated providers for the purposes related to this referral, including: (1) telephone calls and text messages regarding health care, including but not limited to scheduling, reminders, and medication refills; (2) email or mail communications regarding health care, including but not limited to scheduling, reminders, and medication referrals; and (3) other information regarding my health care, billing and health related services and benefits. I have instructed the patient if they wish to revoke this consent, they may contact Memorial Hermann at 713-222-CARE (2273) or opt out directly after receipt of communication.

☐ AM
☐ PM

Provider Signature	Print Name	NPI/MHHS ID.	Date	Time	Contact No.