MEMORIAL HERMANN Home Care

Enteral Nutrition Referral Form
Phone: 281.784.7550 Fax: 281.784.7545

Date:			**Order Type:** ☐ Initial ☐ Revised ☐ Clarification		
Provider Information					
Provider Name:					
Provider Phone Number:		**Provider Fax Number:**			
Patient Information					
Patient Name:		**Patient DOB:**			
Patient Sex:	☐ Male ☐ Female	**Patient Phone Number:**			
Patient Address:					
Primary Insurance:		**Ins ID #:**		**Group #:**	
Secondary Insurance:		**Ins ID #:**		**Group #:**	
Alternate Contact Name:		**Relationship:**		**Phone:**	

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)
Oral Diet:	

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 oral 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 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:	☐ Isosource 1.5	☐ Nutren 2.0	☐ Isosource HN	☐ Fibersource HN	☐ Replete
	☐ Replete Fiber	☐ **Diabetisource***	☐ Other:		
Goal Rate/Volume:			**Calories/Day:**		
Water Flush:			**Beneprotein:**	☐ Yes, _____ scoops per day ☐ No	
Administration:	☐ Bolus	☐ Gravity	☐ Pump	☐ Intermittent	
Supplies Needed:	☐ Syringes (B4304) ☐ Gravity Bags (B4306) ☐ Pump (B9002) ☐ IV Pole (E0776) ☐ Feeding Set (Flush and Feed, B4035) ☐ Feeding Set (Feed only, B4035)				
Length of Need:			**Can Equivalent Formula be Substituted?**	☐ **Yes** ☐ **No**	
Administration Directions:					
Additional Info:					
Diabetisource, Novasource Renal, and Peptide-Based Formulas require additional documentation for necessity, possibly including documentation of failed standard formula.					

					☐ AM ☐ PM	
Signature	**Physician Print Name**	**NPI/MHHS ID.**	**Date**	**Time**		**Contact No.**