nurture
home nutrition by Medi-Rents

Fax to 844.825.3613

Patient Name: **Date of Birth: / /** **Order Date:**

***Diagnoses:** (list all pertinent)

***Prognosis:** (required) **Delivery Date:**

Nutrition Order

Formula _____
(please specify if no substitutions allowed)

Amount daily _____ by _____ via _____ for _____
(cans/ounces/mls per hour/duration of hours) (method) (route) (Length of Need/Refills)

Flush regimen _____ Additional additives: _____
(flush mls per day) (i.e. protein/fiber)

Calories provided per day _____ Cans/Units dispensed per month _____
(Amount per day x 30)

Administration & Tube Supplies: All enteral feeding supplies come with split gauze & tape

☐ **Pump**	☐ **Gravity: Gravity via bag & pole**
Sets- 1 set used daily, 30/month- B4035 Pump- dispense 1, use daily- B9002, Backpack- dispense 1, use daily IV Pole- dispense 1, use daily E0776, Flush Syringes- use daily B4034	1 gravity set used daily, 30/month – B4036 IV pole – dispense 1, use daily E0776 Flushing Syringes- use daily B4034
☐ **Bolus: Bolus via syringe** 1 syringe used day, 30/month – B4034	☐ **Oral** Formula only, no supply

*****NEEDED ONLY IF supply is changed at home*****

☐ *Low Profile–Size: Fr____ cm____ use daily (B4088) extensions use weekly (B9998)

☐ *G-Tube – Size: Fr_____ use daily – (B4087)

☐ *NG NG Size: Fr _____ cm _____ use daily – (B4082) **WITH stylet OR without stylet
(*circle one)

Face to Face Encounter Certification: **I certify that this patient is under my care and that I, a nurse practitioner or physician's assistant working with me had a face to face encounter related to the medical equipment and /or supplies being ordered that meets CMS requirements on:**

***Date last seen by Physician _____/_____/_____**

***Physician Signature:**

_____

Ordering Physician Signature Printed Name NPI Date

By signing this form, I hereby attest that the information on this form is consistent with the determination of the client's current medical necessity and prescription and I certify the prescribed items are appropriate.

Additional documents to be included:

☐ **Demographics sheet** *(Patient contact information, DOB, insurance information)*

☐ **Clinical notes** *(Most recent pertinent visit/nutrition notes, H&P and/or DC summary as available)*

☐ **Following Practitioner** *(Specify name & contact information for following, ongoing care/refills)*

_____ _____ _____

Following Practitioner including NPI (if different from ordering) Phone Fax

Please contact with any questions:

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