Detailed Written Order - Enteral Formula Prescription (To be completed by HCP.)

SECTION 1: PATIENT

Patient's Name:_____ Patient's Date of Birth:_____

Guardian's Name:_____ Patient's Height: _____

Phone: _____ Patient's Weight: _____

Address: _____ Patient's Known Allergies:_____

SECTION 2: DIAGNOSIS

ICD 10 Code(s): _____

Name of Disorder(s): _____ (circle answer below)

Is this a metabolic disorder, inborn error of metabolism?	YES	NO
Is there a non-function or disease of the small bowel which impairs absorption of nutrients?	YES	NO
Is Enteral formula the sole source of nutritional intake?	YES	NO
Is Enteral formula required to maintain weight, strength and overall health?	YES	NO

SECTION 3: FORMULA & PRESCRIPTION

Name of Formula:_____ Place of Service:_____

Procedure Code:_____ Prescribed Qty/ Day:_____

NDC-Format Code:_____ Prescribed Qty/ 30 Days: _____

Formula packaging:_____ Calories provided daily by formula: _____

Date order to take effect:_____ Percent daily caloric intake provided by formula: ____

Length of need/months:_____ Usage: (i.e. quantity, frequency, etc.)_____

(Please note: 99 months equals lifetime of need.) _____

SECTION 4: ROUTE & ADMINISTRATION (Select all that apply.)

- ○ Oral
- ○ NG tube
- ○ G-tube
- ○ J-tube
- ○ Pump
- ○ Bolus via syringe
- ○ Gravity via bag
- ○ Other: _____

SECTION 5: PRESCRIBER

Physician's Name: _____ Date: _____

Physician's Signature: _____ Clinic Name: _____

NPI Number: _____ Clinic Address: _____

Tax ID Number:_____ _____

I certify that I am a licensed physician/practitioner under CMS guidelines and qualified to prescribe medical equipment and supplies. I have reviewed the Detailed Written Order and certify that the medical necessity information is true and complete, to the best of my knowledge. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the product(s) listed. Additional physician notes and other supporting documentation will be provided upon request. I understand any falsification, omission or concealment of material fact may subject me to liability. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the prescribed product(s). A copy of this order will be retained as part of the patient's medical record.