

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): _____

(check 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

Pump

NG tube

Bolus via syringe

G-tube

Gravity via bag

J-tube

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.