

REFERRAL SOURCE/HOSPITAL: _____

DISCHARGE PLANNER/ PHONE NO. _____

ENTERAL PRESCRIBER ORDER FORM

Complete and attached any signed chart orders, current labs, history and physical, then fax to approved pharmacy vendor

FAX (888) 395-9798

CONFIDENTIALITY NOTICE If faxed materials include Protected Health Information (PHI), these records are CONFIDENTIAL. Mariner Advanced Pharmacy shall receive Authorization from the patient prior to releasing or utilizing PHI for reasons other than treatment, payment or healthcare operations. This information is intended solely for the use of the individual named above. If you are not the intended recipient, you are hereby advised that any dissemination, distribution or copying of this communication is prohibited. If you have received this fax in error, please immediately notify the sender by telephone and destroy the original fax message.

Patient Name: _____ Address: _____ Allergy Hx: _____ Agency Name: _____ RN/Caregiver Phone: _____	DOB: _____ City, State, Zip: _____ MRN: _____ Diagnosis _____ Triage Phone: _____ Intake RN Phone: _____
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DELIVERY	STAT ORDER	ROUTINE DELIVERY	OVERNIGHT SHIPPING
	Tube Placed Date: _____	Tube Placement planned: _____	Height: _____ Weight: _____
Type of feeding tube placed or anticipated	NG: Naso Gastric Tube	NJ: Nasojejunal Tube	G/J Tube
	G-Tube: Gastrostomy Tube	J-Tube: Jejunostomy Tube	Other: _____
Type of Connection	Enfit	Legacy	Other: _____
Select Therapy Formulary Items are standard. Non-Formulary Items are special order & may take longer lead time.	FORMULARY ITEMS (STOCKED)		NON-FORMULARY (SPECIAL ORDER)
	Kate Farms Standard 1.4 (Plain)	Kate Farms Pediatric Peptide 1.0 (Vanilla)	
	Kate Farms Standard 1.5 (Plain)	Kate Farms Pediatric Peptide 1.5 (Vanilla)	
	Kate Farms Renal Support 1.8 (Vanilla)	Kate Farms Pediatric 1.2 High Cal (Vanilla)=	
		Kate Farms 1.2 Glucose Support Shake (Vanilla)	
		Isosource High Nitrogen 1.2 (Plain)	
		Isosource 1.5 (Plain)	
		Jevity® 1.5 Cal with Fiber (Plain)	
		Jevity 1.2 Cal Nutritional Supp (Plain)	
		Osmolite® 1.2 (Plain)	
	Nestle Nutren 1.5 (Plain)		
Therapy Duration (estimate): _____			

PRESCRIPTION			
Feeding Method	Syringe Bolusing	Gravity	Pump
Feeding Plan (ie amount & frequency) Additional Water Flushes (indicate amount and frequency) Signature: _____ Date: _____ Prescriber: _____ NPI: _____ Telephone: _____ Fax: _____			RPh Notes
			S CODE
			S
			S
			S
			S
			Notes: _____

Substitution Permissible- in order for a brand name product to be dispensed, the prescriber must hand write "brand medically necessary" in the space. Non-child resistant packaging will be used unless prescriber indicates otherwise. I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

ORDER VERIFIED WITH PRESCRIBER

Verbal order taken and read back by: _____

RPH # _____ Date: _____