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

Patient Name: DOB: MRN:

Address: City, State, Zip:

Allergy Hx:

Agency Name: Diagnosis

RN/Caregiver Phone: Triage Phone: Intake RN Phone:

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 Farms1.2 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)

RPh Notes

S CODE	
S	
S	
S	
S	
S	

Notes:

Signature: _____ Date: _____

Prescriber: _____ NPI: _____

Telephone: _____ Fax: _____

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: _____