Enteral Nutrition & Supplies Standard Written Order

Fax: 602-428-6841
Phone: 480-795-7955
Orders@MyTritonSupply.com

Patient Name: _____ Phone #: _____

Address: _____

Ins ID#: _____ Patient DOB: _____ Sex: ☐ Male ☐ Female

Refer to Enteral coverage criteria sheet for all required documentation.

ENTERAL:

Date of Last Visit: _____

Diagnosis and Code: _____

Length of Need (# of months) _____ 1-99 (99=lifetime) Patient Height: _____ in. Weight: _____ lbs.

Formula:

Formula Type #1: _____ Substitution Allowed Calories per day: _____

Formula Type #2: _____ Substitution Allowed Calories per day: _____

Delivery Method: ☐ Oral (i.e. drinking) ☐ Syringe (Bolus) ☐ Gravity ☐ Pump

Pump Settings: Feed Rate (mL/hour): _____ Flush (mL/hour): _____ Total Volume to be fed: _____

Gravity: _____ mLs/hr _____ hours or _____ times per day

Syringe: _____ mLs/hr _____ hours or _____ times per day

Tube Type: ☐ Gastrostomy (G) Tube 1 every 3 months
☐ Jejunostomy (J) Tube 1 every 3 months
☐ Nasogastric (NG) Tube 1 every month
☐ ENFit
Size: _____ ☐ Standard ☐ Low Profile

Supplies:

☐ Feeding Pump with IV Pole
☐ Syringes 30/mo may select multiple sizes ☐ 20 mL ☐ 60 mL
☐ Gauze (each) select one size ☐ 2x2 70/mo ☐ 4x4 50/mo
☐ Tape 1/month ☐ Waterproof ☐ Non-Waterproof
☐ Other: _____
☐ Extension Sets 4/mo
☐ Feeding Bags 30/month
☐ IV Pole (required for Gravity Method)
☐ Feeding Pump Backpack

Provider Certification:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

Provider's Signature: _____ Date: _____ NPI: _____

Providers Name: _____ Telephone: _____