Enteral Order Form

Patient Name: _____ DOB: _____

Duration of Need: _____ Months (max of 12 months) Height_____Weight_____

Main Diagnosis Code: _____ Other Diagnosis Code: _____

☐ **BOLUS** ☐ **PUMP** ☐ **GRAVITY**

Formula:

1) Type:_____

Calories per day: _____ OR _____ml _____times a day

2) Type:_____

Calories per day: _____ OR _____ml _____ times a day

Enteral Equipment/Supplies **30 DAY SUPPLY**

□ Feeding Pump Rate: _____mls / hr **EPUMP** **JOEY** **IV POLE**

OR _____

□ Feeding Bags (Circle): Size: 500mls 1000mls 1200mls Feed and Flush **QTY** _____

□ Extension Sets (Circle) AMT _____ QTY_____ ,.AMT _____QTY_____

Mickey _____ QTY _____, Mickey _____ QTY _____

□ Syringes: Size (Circle): 1ml 3ml 5ml 10ml 30ml 60ml

Qty Each _____ _____ _____ _____ _____ _____

Feeding Tubes

□ Mickey Button _____Fr _____cm Dispense: 1 every _____ months

□ Mini One/AMT _____Fr _____cm Dispense: 1 every_____ months

□ NG Tube _____Fr _____cm Dispense: 2-3 every _____month

Dressings / Wound Care

□ Drain sponges: 2x2_____ 4x4_____ Other: _____

□ Gauze pads: 2x2_____ 4x4 _____ Other: _____

Other:_____

□ Medipore tape: 1”x 5 yd_____ 2”x10yd_____ 3”x10 yd_____ 4”x10 yd_____

Other: _____

Misc □ Lopez Valve_____ □ Enteral Graduate_____ □ Securement Device_____

Additional Orders:

Item: _____ Item: _____

Qty/Month: _____ Qty/Month: _____

Provider Signature: _____ Date: _____/_____/_____

Print Name:_____

****Demographics and Nutrition/Clinical documentation needs to be faxed with order****

Bigskymanagedcare.com
900 13th Ave S • Great Falls, Montana 59401 • 406-315-1989 Fax 406-315-1988