BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

HOME ENTERAL NUTRITION (EN) ORDER FORM

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 470.922.3656

Name:	DOB:	Feeding Tube
Phone:	Date:	☐ NG ☐ GJ tube
Sex: ☐ Male ☐ Female	Patient's PCP:	☐ G-tube ☐ J-tube
Weight: ☐ lbs ☐ kg	Height:	

REQUIRED DOCUMENTATION

Condition that prevents oral intake or absorption/indication for EN therapy:

NOTE: Must provide clinical documentation to support patient's condition. May include, but not limited to: H&P, RD notes, diagnostic report, swallow study, etc.

Length of Need Statement (LON)

- *MUST be included in a progress note and signed by the physician*
- Example of LON: "Due to patient's [condition] tube feeding is needed for [insert amount of time here]"
- Medicare requires patient to have a permanent impairment considered long and indefinite duration

Note: Medicare does recognize time frames such as "lifetime" as appropriate

Disclaimer - failure to receive appropriate documentation may delay start of therapy and delivery

EN MANAGEMENT - DIETITIAN CONSULT (CHECK THE BOX)

☐ Checking the box allows the Biocare Infusion Registered Dietition (RD) to conduct a comprehensive nutrition assessment, provide evidence-based, initial EN orders and ongoing adjustments to the enteral plan of care while admitted to our service. The treating provider will subsequently receive faxed orders as notification of any changes, and as appropriate, will require signature.

HOME HEALTH - IN MOST CASES, HOME HEALTH WILL COMPLETE TUBE FEEDING INSTRUCTIONS

Does the patient have home health set up? ☐ Yes ☐ No If yes, indicate home health agency:

Does Biocare Infusion need to arrange home? ☐ Yes ☐ No

DO NOT COMPLETE THE SECTION BELOW IF DIETITIAN CONSULT HAS BEEN ORDERED

Enteral Formula: | Formula substitutions allowed ☐ Yes ☐ No

Enteral Bolus Order	Enteral Gravity Order	Enteral Pump Order
Cans per feeding: _______________	Cans per feeding: _______________	Rate: ___________ mL/hour
Feedings per day: _______________	Feedings per day: _______________	for _____________ hours/day
Total cans per day: _______________	Total cans per day: _______________	Water flushes to total _______ mL/day
Water flushes to total _______ mL/day	Water flushes to total _______ mL/day	

Modular: ________________________________ Dose/Instruction: ________________________________

PROVIDER INFORMATION

Provider Name: ____________________________ Signature: Date: ___________

Provider NPI: ______________ Phone: ______________ Fax: _____________ Contact Person: _________________

☐Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: ______________________ State: ___________

View our locations here:

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