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# Physician's Written Order
## Enteral Nutrition & Supplies

All fields are required to process an order.

edgepark® Medical Supplies

**Start Date**_____ / _____ / _____

**patient**

**First:** _____ **Last** _____ **MI** _____ **Patient DOB:** _____/_____/_____ **Gender** ☐ **M** ☐ **F**
**Address:** _____ **Phone #:** _____
**City:** _____ **State:** ____ **ZIP:** _____ **E-mail Address:** _____

**doctor**

**Prescribing Physician Name:** _____
**Street Address:** _____
**City:** _____ **State:** _____ **Zip:** _____
**Phone:** _____ **Fax:** _____
**NPI #:** _____

**insurance**

**Primary Insurance:** _____
**Policy/ID #:** _____
**Group #:** _____
**Phone #:** _____

**Secondary Insurance:** _____
**Policy/ID #:** _____
**Group #:** _____
**Phone #:** _____

**diagnosis**

## ICD-9/ICD-10 Description

☐ V44.1/Z93.1 Gastrostomy
☐ 560.9/K56.60 Intestinal Obstruction, Unspecified
☐ 783.21/R63.4 Abnormal Loss of Weight
☐ 783.41/R62.51 Failure to Thrive/Gain Weight (Pediatric)
☐ _____ _____

| ITEM # | PRODUCT DESCRIPTION | QTY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Estimated Length of need:**____ **months** (99 = Lifetime)

*****FOR MEDICARE PATIENTS, PLEASE INCLUDE MEDICAL RECORDS*****

**Use Y for Yes, N for No or D for Does Not Apply unless otherwise noted:**

_____ 1. Does the patient receive more than ½ of their daily caloric intake through Enteral Nutrition?

_____ 2. Is Enteral nutrition the only source of nutritional intake which the patient can consume/ingest?

_____ 3. Does the patient require Enteral feedings to provide sufficient nutrients to maintain weight and strength to commensurate with the patient's overall health status?

_____ 4. If Enteral Nutrition is being routed for administration via a tube, please indicate the route: Everything orally fed.

1- Gastrostomy Tube 2- Jejunostomy Tube 3- Nasogastric Tube 4- Other _____

_____ 5. Please indicate the prescribed calories per day? _____ per day
Does the number of prescribed calories average between 20/35 cal/kg/day? If no, please indicate medical reason.
_____

_____ 6. Days per week administered? (Enter 1 — 7) Formulated to be administered 7 day units unless otherwise noted.

_____ 7. Please indicate if the patient has a documented allergy or intolerance to semi-synthetic nutrients?

I certify that I am the physician identified on this form. I have reviewed the Physician's Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. I certify I am qualified, under CMS guidelines, to sign and prescribe medical equipment and supplies. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this Written Order. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the products listed and physician notes and other supporting documentation will be provided to Edgepark upon request. I understand any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

**Physician Signature:** _____ **Date:** _____
(Stamps are not acceptable)

**Printed Name:** _____



Version #: 092815/ENT