# Enteral Referral Order Form

| SEND THE COMPLETED FORM TO: | |
|---|---|
| Company: | |
| Attn: | |
| FAX#: | Email: |

## PATIENT INFORMATION

| | | | | |
|---|---|---|---|---|
| First: | Last: | MI: | DOB: | |
| Address: | | City: | State: | Zip: |
| Home Phone: | Mobile Phone: | | | |
| Caregiver Name: | Relationship: | | Phone: | |

## INSURANCE INFORMATION

| **Primary Insurance** | | | **Secondary Insurance** | | |
|---|---|---|---|---|---|
| Subscriber Name: | | DOB: | Subscriber Name: | | DOB: |
| Member ID: | Group: | Plan: | Member ID: | Group: | Plan: |
| Insurance Claims Phone: | | | Insurance Claims Phone: | | |

## PHYSICIAN ORDER (Dispensing Order/Detailed Written Order)

Real Food Blends® - HCPCS B4149 Pouches per day:

- ☐ Select™ Chicken, Zucchini & Potatoes (410 Cal)
- ☐ Select™ Turkey, Pears & Pumpkin (410 Cal)
- ☐ Salmon, Oats & Squash (330 Cal)
- ☐ Turkey, Sweet Potatoes & Peaches (320 Cal)
- ☐ Eggs, Apples & Oats (320 Cal)
- ☐ Quinoa, Kale & Hemp (340 Cal)
- ☐ Chicken, Carrots & Brown Rice (340 Cal)
- ☐ Beef, Potatoes & Spinach (330 Cal)
- ☐ Mini Prunes, Pears & Pumpkin snack (100 Cal)

Free Water Flushes: Start Date:

If enteral nutrition is being routed for administration via tube, please indicate the route: ☐ Gastrostomy Tube ☐ Other _____

ICD-10 Diagnosis Code:

**DISPENSE AS WRITTEN, NO SUBSTITUTIONS**

Method of Administration: ☐ Syringe Bolus ☐ Gravity ☐ Pump

Start Date: Estimated length of need: _____ months _____ # Refills

## PHYSICIAN INFORMATION

| | | |
|---|---|---|
| First Name: | MI: | Last: |
| Street Address: | | |
| City: | State: | Zip: |
| Physician's Phone Number: | Fax: | |
| NPI #: | Date: | |
| Physician/Practitioner Signature: | | (stamps are not acceptable) |

I certify that I am the physician/practitioner identified on this document and I have reviewed this Enteral Referral Order Form. I attest that any information presented on this form is accurate to the best of my knowledge. I understand that medical records, insurance card, or additional information may be required for insurance coverage. I am authorized to provide the information contained in this form to the recipient, an authorized DME/home infusion supplier, and the patient/caregiver listed on this form is aware that the recipient may be contacting them for additional information to process this order, as needed. I understand that I should not send this form to Nutricia North America. I confirm I am qualified, under CMS guidelines, to sign and prescribe medical equipment and supplies.

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**Please send this enteral order form and associated clinical documentation directly to a DME/home infusion supplier.**