enū NUTRITION

For questions, contact us at
support@enu-nutrition.com

TotalCareRX
SPECIALTY PHARMACY

EScribe to TotalCareRX
(NPI: 1821329731), Or Fax Form to:
718-504-7426
223-10 Union Tpk. Oakland Gardens, NY 11364
For More Information Call: 718-762-7111, x562
Email: EJones@TotalCareRx.com

Physician Written Order

PATIENT INFORMATION:

First | MI | Last

DOB | Gender

Street | City | State | Zip

Phone | Email

Caregiver Name | Phone | Email | Relationship

INSURANCE INFORMATION:

Primary Policy Holder Name | DOB | Secondary Policy Holder Name | DOB

Primary Insurance | Phone Number | Secondary Insurance | Phone Number

Policy/ID | Group # | Policy/ID | Group #

PHYSICIAN INFOMRATION:

First | MI | Last

Street | City | State | Zip

Fax | NPI#

Estimated Length of need: _____ months *(99 = lifetime)*

Primary Diagnosis: _____

Weight: _____
Height: _____

DIAGNOSIS
Start date: _____/_____/_____

1. Is enteral nutrition the only source of nutritional intake which the patient can consume/ingest? ☐ **Yes** ☐ **No**
2. Does the patient require enteral feeding to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status? ☐ **Yes** ☐ **No**
3. If enteral nutrition is being routed for administration via tube, please indicate the route:
   ☐ **Gastrostomy Tube** ☐ **Jejunostomy Tube** ☐ **Nasogastric Tube** ☐ **Other** _____
4. **Prescribed calories per day**: _____ or _____ *(ounces/day)*
5. Method of administration of the enteral nutrition is *(check all that apply)*:
   ☐ **Syringe** ☐ **Pump** ☐ **Gravity** ☐ **Oral**
6. Formula Type/s used to fill order:
   ☐ **ENU Complete Nutrition Shake - Vanilla (B4150)** ☐ **ENU Complete Nutrition Shake - Chocolate (B4150)**
   ☐ **ENU Pro3+ Powder w/Leucine (B4153)**
7. **Days per week administered** *(Enter 1 - 7)* _____ *Formulated to be administered 7 day units unless otherwise noted*
8. **Feeding schedule** _____

Printed Physician Name: _____

Medical records may be required for insurance coverage * FOR MEDICARE PATIENTS, PLEASE INCLUDE MEDICAL RECORDS*****

I certify that I am the physician/practitioner identified on this form and I have reviewed the Physicians 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. I understand 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/Practitioner Signature: _____ *(No Stamps Allowed)* Date: _____