Physician's Written Order Enteral Nutrition

PATIENT *(Fill in this portion and take to physician's office)*

First _____ MI _____Last _____ Gender _____
Street _____ City _____ State_____ Zip _____
DOB / / Phone _____ Email _____
Caregiver Contact _____Phone _____ Relationship _____
Primary Insurance _____ Secondary Insurance _____

My current home medical supplier: _____

I am interested in:
___ ENU® Nutrition Shakes Chocolate or Vanilla **(B4150)**

___ ENU® Pro 3+ Unflavored Powder (B4153) **Applied For*

PRESCRIBING PHYSICIAN *(Physician office fills out and faxes to Medical Supplier)*

First _____ MI _____ Last _____
Hospital / Clinic Name_____
Street _____ City _____ State _____ Zip_____
Phone _____ Fax _____ NPI# _____

PRESCRIPTION INFORMATION

Start Date: / / Estimated Length of Need: _____ months (99 = lifetime)
Height: _____Weight: _____ICD-10 Diagnosis Code: _____

1. Method of administration of the enteral nutrition is:
   ☐ Syringe ☐ Pump ☐ Gravity ☐ Oral
2. If tube fed, please indicate the route:
   ☐ Gastrostomy Tube ☐ Jejunostomy Tube ☐ Nasogastric Tube ☐ Other _____
3. Prescribed calories per day: _____ or _____ *(ounces/day)*
4. Formula type/s used to fill order:
   _____ **ENU Nutrition Shake Vanilla or Chocolate** *(circle one)* ____ **ENU Pro 3+ Powder**
5. Quantity to Dispense: _____☐ mL ☐ carton ☐ Frequency of Use: ☐ day ☐ month

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. The patient's record supporting documentation that substantiates the utilization and medical necessity of the products listed and physical notes and other supporting documentation will be provided to Kate Farms upon request. 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:_____ Date: _____
(Stamps are not acceptable)
Printed Name: