University of Michigan Hospitals and Health Centers

HOME ENTERAL NUTRITION ORDER FORM

Estimated Duration of Need**: 12 months (*please specify number of months*) **START of Service Requested** (Date): **Diagnosis / Medical Need for Enteral Feeding:** **ICD9 / ICD10**: **The ordering physician has notified the patient and/or representative that they are in need of durable medical equipment and that they are contacting the provider for equipment/supplies and delivery arrangements.**	**Patient Name**: **Birthdate:** **MRN #:** **Height**: (in or cm) **Current Weight**: (lbs or kg)

Feeding Tube: **Brand:** **Size:** ❒ NG ❒ ND/NJ ❒ G-Tube (gastrostomy) ❒ J-Tube (jejunostomy) ❒ GJ-Tube ❒ G-Tube Button ❒ TEP (tracheoesophageal puncture) ❒ None – Oral	❒ **WIC Eligible** **Name** of Formula provided by WIC: **Volume**: _____ mL or grams (for powders) **per day** **Name of FORMULA**: (to be provided by **Supplier**) **Volume:** cans, mL or grams (for powder) /**per day** **Estimated Caloric Needs per day:** kcals/day	**Other Orders**: ❒ IV Pole (once) ❒ **Button (1 every 8 weeks for duration of need)** **Size:** ❒ All ancillary supplies to support formula administration. **For SYRINGE Gravity feeds**: ❒ NG Tubes (2 every 4 weeks for duration of need) ❒ Extension Set (35") for NG (2 every week for duration of need; use with formula ≤ 24 kcal/ounce) ***MUST Select One Below:*** X- No Nursing Needed – nursing will be made available on an as needed basis ❒ Nursing Visits Needed – up to 3 visits weekly

METHOD of Administration: ❒ ORAL[PA] ❒ SYRINGE Push (supply kit B4034; provide maximum of one per day for duration of need**)** ❒ SYRINGE Gravity (supply kit B4034; provide maximum of of up to 2 per week for duration of need) ❒ GRAVITY (supply kit B4036; provide one per day for duration of need) ❒ PUMP (pump + supply kit B4035; provide one per day for duration of need) *indicate justification* [PA] Prior Authorization Required for Oral Administration & Specialty Formulas. Attach medical documents including growth/weight history, nutrient needs or restrictions, other interventions attempted.	***PUMP needed** due to:* ❒ Rate < 100 ml per hour ❒ Small bowel feedings ❒ Aspiration Risk ❒ Reflux ❒ Severe Diarrhea ❒ Dumping Syndrome ❒ Glycemic Instability ❒ Circulatory Overload

Nutrition Supplementation:

❒ None (NPO) ❒ Transitioning to Oral Diet: _____ (Providing _____% of Daily Estimated Needs)

✻**Ordering Physician** (Printed Name)**:** **Signature**: _____ (***Must*** be signed by a ***physician*** and be ***legible)*** **Date: _____** **Address**:	**Physician Following** Patient's At-Home Services: Name: Office Telephone: **Supplier**: HomeMed, 2850 S. Industrial Hwy Suite 50, Ann Arbor, MI 48104 Tel: 800.862.2731 Fax: 734.975.3079

✻***Medicare patients require a PECOS enrolled physician.***