GoodCare by CPCI

**Home Medical Equipment and Oxygen**
450 State Route 664 North • P.O. Box 997 • Logan, Ohio 43138
Phone: (740) 385-6177 or 1-800-423-3615 •FAX: (740) 385-0474
242 W. 6th Ave. • Lancaster, Ohio 43130
Phone: (740) 652-9250 or 1-800-423-3625 •FAX: (740) 652-9253

# Enteral Nutrition Order

**Dear Doctor,** **Date:_____**

**Below is the information confirming your order for enteral nutrition for:**

**Patient Name_____HIC# _____**
**Address_____City_____State___Zip_____**

**The clinical information provided to us by __you; __your staff;**
**__Hospital:_____Other:_____**

**Ht._____Weight_____**
**Diagnosis (including ICD-9 Codes):_____**

**Equipment/Supplies Ordered:_____**
**_____**
**Start Date:_____Date Patient last examined_____**

**Does this patient have permanent non-function or disease of the structures that normally Permit food to reach or be absorbed from the small bowel? ____Yes ____No**

**Does the patient require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status? ____Yes ____No**

**Enteral Nutrient: _____**
**Calories per Day:_____or: cc/hr:_____**
**Enteral Infusion; Hours/Day:_____Days/week:_____**
**Method of Administration: ___Syringe ___Gravity ___Pump**
**If PUMP is ordered, why is pump necessary?_____**
**Does the patient have a documented allergy or intolerance to semi-synthetic nutrients?__Yes __No**
**Does the patient have diabetes? __Yes __No; Other clinical information:_____**
**_____**
**Estimated Length of Need: __Lifetime __3 months __6 months __Other**

**Physician Name_____NPI_____**

**Physician Signature_____Date_____**

**Thank you very much for your referral. Please return this signed form by FAX to:**
**____Logan (740-385-6177) ____Lancaster (740-652-9253**

***mjf*** **GOODCARE by CPCI**