APRIA®

Enteral Nutrition Form

Fax completed form to: ______________________

Your Apria Representative ______________________

Branch Location ______________________ **Phone** ______________

***REQUIRED FIELD**

Referral Facility Name ______________________ Anticipated Discharge to Home Date ____ /____ /_____

Referral Contact Name ______________________ Phone ______________ Fax ______________

PATIENT INFORMATION

Patient Name* ______________________ Date of Birth*____ /____ /_____

Gender*: ☐ M ☐ F Height*_______ Weight*_______ Food Allergies: ☐ None ☐ ______________

Primary Phone*______________________ Secondary Phone ______________

Delivery Address*: Street ______________________ City ______________ State _____ Zip ________

Insurance Provider ______________________ Insurance ID # ______________ (or submit copy of face sheet)

Primary Care Physician ______________________ Phone ______________

Home Health Agency ______________________ Phone ______________

ENTERAL ORDER

1 **Order Date*** ____ /____ /_____ ☐ Initial start ☐ Revised/changed

2 **Diagnosis ICD-10*** ________ ________ ________ ________

3 **Length of Need*** ____ months ☐ lifetime (99 months)

4 **Route*** ☐ G-tube ☐ J-tube ☐ NG-tube ☐ NJ-tube Other ______________ | ☐ ENFit Tube Connection

5 **Formula Name*** ______________________ or equivalent formula ☐ No formula substitutions

6 **Formula Total*** Volume _____ mL per day **OR** _____ cartons per day (Enter volume mL or cartons, not both)

Total calories from formula *________ per day, *________ per month Additional info ______________

7 **Formula Name** ______________________ or equivalent formula ☐ No formula substitutions

8 **Formula Total** Volume _____ mL per day **OR** _____ cartons per day (Enter volume mL or cartons, not both)

Total calories from formula ________ per day, ________ per month Additional info ______________

9 **Modular Name** ______________ Daily schedule ______________ Total calories ________ per day, ________ per month

10 Method*: Enter method, feeding schedule, AND supply kit to be dispensed

☐ **Syringe Bolus**	☐ **Gravity-Drip Bag**	☐ **Pump Infusion with Bag**
Volume _____ mL/feeding, ____ times/day	Volume _____ mL/feeding, ____ times/day	Rate _____ mL/hr, for ____ hours/day
OR _____ cartons/feeding, ____ times/day	**OR** _____ cartons/feeding, ____ times/day	Additional info ______________
☐ Syringe, 30/month (B4034)	☐ Gravity Bag, 30/month (B4036)	☐ Pump Bag, 30/month (B4035)
	☐ IV Pole (E0776)	☐ IV Pole (E0776) ☐ Pump (B9002)

11 Water Flush Total Volume _____ mL per day

Daily Schedule Volume _____ mL water before and after feedings by syringe

Volume _____ mL water, _____ times/day by syringe **OR** every _____ hours by syringe

Rate of _____ mL/hr water every _____ hour(s) by pump when running

FEEDING TUBE SUPPLY REPLACEMENT AT HOME (Only fill out this section if providing replacements)

Extension Sets Low Profile-Button brand ______________________, compatible extension sets 4/month (B9998)

Extension Set type: ☐ Continuous (right angle) ☐ Bolus (straight) Length: ☐ 12" ☐ 24"

G-tube Replacement Feeding Tube brand ______________ French size (Fr) _______ Stoma length (cm) _______

☐ Low Profile-Button, 1 ea/3 months (B4088) ☐ Standard Profile Balloon, 1 ea/3 months (B4087)

NG-tube Replacement Feeding Tube brand ______________ or equivalent French size (Fr) _______ Tube length (cm) _______

☐ With Stylet, 3 ea/3 months (B4081) ☐ Without Stylet, 3 ea/3 months (B4082) ☐ Weighted ☐ Non-weighted

Other Supplies ______________________

If you have questions, please contact an enteral nutrition specialist at (844) 260-1788 in the Continental U.S. or (800) 454-5672 in Hawaii. By signing below, I authorize the use of this document as a dispensing prescription. I understand the final decision with respect to ordering a tube feeding product for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my medical records support the medical need for the items prescribed.

Print prescriber name*______________________ **NPI #***______________

Prescriber signature*______________________ **Date*** ____ /____ /_____

Internal Only: Any prefilled portions done by ______________________

©2021 Apria Healthcare Group LLC