APRIA HEALTHCARE®

Refresh™ HOME ENTERAL NUTRITION SUPPORT

Tube Feeding Care Program

Enteral Nutrition Department Fax:

(844) 281-1309

Enteral Nutrition Support Team Phone: (844) 260-1788

REFERRAL SOURCE

Referred by _____ Referred date _____ Start date _____ Revised date _____

Contact name/Institution _____

Phone/pager _____ Fax _____

PATIENT INFORMATION

Patient name _____ DOB _____
Last First

Home phone _____ Mobile phone _____

Delivery address: Street _____ City _____ State ____ Zip _____

ORDER/RX

ICD-10 _____ Formula(s) _____ ☐ HCPC code _____ ☐ Or equivalent formula ☐ No substitutions

Total volume/day _____ml Rate _____ml/hr for _____hrs **OR** _____cans/day, _____days/wk, _____calories/day

Total Free Water _____ Flush before administration _____ml Flush after administration _____ml

Administration supplies as required: ☐ Yes ☐ No

Diabetic: ☐ Yes ☐ No Allergies _____ Length of need: _____

Home Health Agency _____ Phone _____

☐ Other/DME _____

ADMINISTRATION METHOD

☐ Pump rate: _____ml/hr x _____hours/day (1 set/d-B4035, pump – B9002, IV pole – E0776)

☐ Gravity via bag (1 bag/d-B4036 and IV pole – E0776)

☐ Syringe/Bolus (1 syringe/day – B4034)

☐ Feeding tube supplied: ☐ Yes ☐ No

☐ Tube type: NG _____ GT _____ JT _____

Naso tube (B4082): _____Fr _____Cm _____Stylet _____Wt

G-tube (balloon B4087): _____Fr Low profile (B4088) size: _____Fr _____cm

Apria dietitian assessment for formula recommendations? ☐ Yes ☐ No

Referring MD _____ Address _____

Phone _____ Fax _____ License # _____ NPI # _____

Phone orders received from _____ Date/time _____

If you have questions, please contact the Enteral Nutrition Support Team at (844) 260-1788. By signing below, I authorize the use of this document as a dispensing prescription. I understand that 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.

Physician signature _____ **Date** _____