Upstate HomeCare

The Best for Getting Better

Enteral Order Form

Phone: (888) 648-2211 Ext. 6058

Fax: (315) 802-5780

FAX

To: Upstate HomeCare **Fax#:** 315-802-5780

From: (Name) (Location) (Phone#)

RE: New Referral **Pages:**

Patient Name: **Date of Birth:**

Diagnosis: **Medicaid CIN#:** **Medicaid PA#:**

Allergies: **Height:** **Weight:**

Access:

Referral Checklist - Please Attach the Following

☐ **Demographics** ☐ **H&P** ☐ **Progress/Nutritional Notes** ☐ **Labs** ☐ **Med Profile**

Medication Ordered

Formula: **Sig:** ___ **cans via** ___ **daily** **Quantity:** ___ **can/mth** ☐ **Refills: 5**

Formula: **Sig:** **Quantity:** ☐ **Refills: 5**

Formula: **Sig:** **Quantity:** ☐ **Refills: 5**

Formula: **Sig:** **Quantity:** ☐ **Refills: 5**

Modality:

☐ Enteral Pump (lifetime)	☐ Quantity 1
☐ Pump Supply Kit	☐ Refill x5
☐ Bolus Supply Kit	☐ Refill x5
☐ Gravity Supply Kit	☐ Refill x5

Access:

☐ MK Button	_____ Fr	_____ cm	☐ Refill x1
☐ AMT Button	_____ Fr	_____ cm	☐ Refill x1
☐ NG Tube	_____ Fr	_____ inches	☐ Refill x5
☐ G Tube	_____ Fr		☐ Refill x5

Prescriber Signature: _____ **Date:** _____

Print Name: _____ **NPI#:** _____

By signing this form, you, as the following physician are authorizing Upstate HomeCare to transcribe the above order into verbal orders.