115 Marcon Drive
Lafayette, LA 70507

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337-291-9920 (Fax)
877-236-6687 (Toll-Free)

MEDICAID TUBE FEEDING (ENTERAL) REFERRAL FORM

DEMOGRAPHIC INFORMATION

PATIENT: ______________________________

MAILING ADDRESS: ______________________________

DELIVERY ADDRESS: ______________________________

CITY / STATE/ ZIP: ______________________________

HEIGHT: ____________ WEIGHT: ____________

ALLERGIES: ______________________________

DATE: ______________________________

PHONE: ______________________________

SS#: ______________________________

DATE OF BIRTH: ______________________________

MEDICAID #: ______________________________

OTHER INSURANCE#: ______________________________

DIAGNOSIS INFORMATION

DIAGNOSES w/CODES: ____________ (__________)

______________________ (__________)

______________________ (__________)

______________________ (__________)

MENTAL STATUS

_______ AWAKE, ALERT & ORIENTED

_______ FORGETFUL

_______ DEPRESSED

_______ DISORIENTED / CONFUSED

ORDER

Method of Administration: *CIRCLE ONE:* SYRINGE - GRAVITY - PUMP

Administer (Formula): ____

____ for a total of ____________

calories per day via gastrostomy feedings until discontinued. ***THIS SUPPLEMENT CONTSTITUTES 100% OF THE PATIENTS DAILY INTAKE.***

MONTHLY SUPPLIES

Formula: ______________________________ Cans Per Day: ________ X 30 = ________ Cans Per Month

Formula: ______________________________ Cans Per Day: ________ X 30 = ________ Cans Per Month

IV Pole: YES / NO *** **Enteral Pump**: YES / NO *** **30 (60cc) Enteral Syringes**: YES / NO *** **30 Enteral Pump Feeding Bags**: YES / NO

Feeding Extension Tubes: YES / NO If YES, Qty: _______ **Gastrostomy Button Kit (1 Every 3 Months)**: YES / NO If YES, Size: ____________

Other Supplies (tape, gauze…): ____

WITHOUT THIS ENTERAL THERAPY, THE PATIENT WILL BE UNABLE TO MAINTAIN A LIFE SUPPORTING NUTRITIONAL STATE. THIS THERAPY IN THE PATIENT'S HOME IS IN LIEU OF CONTINUED AND/OR HOSPITALIZATION.

REFERRAL SOURCE INFORMATION

____
REFERRAL SOURCE NAME

____
CONTACT PERSON (please print)

____
REFERRAL SOURCE ADDRESS

____
PHONE and FAX

____
ORDERING PHYSICIAN (please print)

X______________________________
PHYSICIAN SIGNATURE