

MEDICAID ENTERAL PRESCRIPTION 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 CONSTITUTES 100% OF THE PATIENTS DAILY INTAKE.**

MONTHLY SUPPLIES

Formula: _____ Cans Per Day: _____ X 30 = _____ Cans Per Month

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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)


PHYSICIAN SIGNATURE