115 Marcon Drive
Lafayette, LA 70507

TotalCare

337-291-9919 (Phone)
337-291-9920 (Fax)
877-236-6687 (Toll-Free)

MEDICAID ENTERAL PRESCRIPTION FORM

DEMOGRAPHIC INFORMATION

PATIENT: _____ DATE: _____
MAILING ADDRESS: _____ PHONE: _____
DELIVERY ADDRESS: _____ SS#: _____
CITY / STATE/ ZIP: _____ DATE OF BIRTH: _____
HEIGHT: _____ WEIGHT: _____ MEDICAID #: _____
ALLERGIES: _____ 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 PATIENT'S DAILY INTAKE.*** To allow for substitution of formula when the above is not available, please check (✓) here: _____.

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

_____ X _____
ORDERING PHYSICIAN (please print) **PHYSICIAN SIGNATURE**