Covenant Home Infusion
7509 Marsha Sharp Fwy Suite 101
Lubbock, TX 79407
806-725-6327 Fax: 806-725-4942

ENTERAL NUTRITION THERAPY ORDER

PATIENT NAME: _____ DOB: _____

DIAGNOSIS: _____ START DATE: _____

Please select an order from the following:

☐_____ continuous via _____ tube @ _____ ml/hr to provide _____ Kcal/day and _____ units/month. Include pump, pole, and bags daily.

☐_____ cyclic via _____ tube @ _____ ml/hr x _____ hours daily to provide _____ Kcal/day and _____ units/month. Include pump, pole, and bags daily.

☐_____ gravity feeds via _____ tube @ _____ cartons daily to provide _____ Kcal/day and _____ units/month. Include pole and gravity kits daily.

☐_____ bolus via _____ tube @ _____ cartons daily to provide _____ Kcal/day and _____ units/month. Include bolus kits daily.

Estimate length of therapy: _____ months

☐Yes ☐ No Does documentation in the medical record support the patient having a permanent non-function or disease of the structures that normally permit food to reach or be absorbed from the small bowel?

Physician name (printed): _____ NPI: _____

Physician Signature: _____

Physician address: _____

Date: _____