PROVIDENCE HOME MEDICAL EQUIPMENT		**Enteral Tube Feeding Prescription Referral Form** *Hospital Discharge Use Only*	PROVIDENCE Health & Services
6410 NE Halsey, Suite 500 Portland, OR 97213 Phone: (503) 215-4663 Fax: (503) 215-4985	**Salem Location:** 2508 Pringle Road Salem, OR 97302 Phone: (503) 585-4027		

Date:	**Ordering Contact:**	**Phone #:**	**Fax #:**

PATIENT DEMOGRAPHICS

Patient Name:	**DOB:**	**Primary Phone #:**	
Address 1:	**Apt. #:**	**City/State/Zip:**	
Alternate Contact/Relationship:		**Alt. Phone #:**	
Primary Insurance Plan:	**Ins. ID#:**		**Group #:**
Secondary Insurance Plan:	**Ins. ID#:**		**Group #:**
Subscriber Name:	**Relationship:**		**Subs. DOB:**
Primary Care Physician (if diff.):		**Phone #:**	**Fax#:**

PRESCRIPTION ORDERS

Ht.: in.	**Wt.:** lb.	**ICD-10 Diagnosis Code(s):**

Length of Need: ☐ **Less than 3 months** - indicate weeks needed: _____ ☐ **3 months** ☐ **6 months** ☐ **1 year** ☐ **Lifetime**

Tube Feeding Order:	For adults*, may equivalent formula be substituted? ☐ **Yes** ☐ **No** ***No pediatric substitutions allowed**
	Oral Diet:
	Formula: ☐ **Ready to Feed** ☐ **Powder** ☐ **Concentrate**
	Tube Feeding Flush and free water ml/day: _____ *(This includes oral fluid if applicable and tube flushes. Flush tube before and after feeding and medications.)*
Method of Admin.:	☐ Syringe/Bolus: _____ **Goal rate or volume:** _____ ☐ Gravity: _____ ☐ Pump: **Kcals per Day:** _____

Patient has reached goal rate at discharge: ☐ **Yes** ☐ **No - If no, rate (ml/hour) or volume (ml/feeding) at D/C:**

If not at goal, specify advancement instructions:

Feeding Tube Type: (Check One)	☐ Nasogastric French Size: _____	☐ Gastrostomy (G Tube) French Size: _____	☐ Percutaneous endoscopic gastrostomy (PEG Tube) French Size: _____	☐ Button/LP G-Tube French Size: _____
Date of Placement: _____	☐ Nasojejunal French Size: _____	☐ Gastrojejunostomy (G/J Tube) French Size: _____	☐ Jejunostomy (J-Tube) ***Jejunal Feedings Require Pump* French Size: _____	Stoma Length: _____ Brand: _____

Is the patient currently being seen by a Home Health RN? ☐ Yes ☐ No

If no, is a Home Health referral needed for tube feeding instruction and management? ☐ Yes ☐ No

PHYSICIAN / DIETITIAN: PLEASE CONTACT DISCHARGE PLANNER WHEN FORM HAS BEEN COMPLETED.

Registered Dietitian (RD):	**Contact #:**
Physician Printed Name:	**NPI#:**
Physician Signature: X	**Date:**

[UNABLE TO FILL PATIENT'S PRESCRIPTION WITHOUT PHYSICIAN SIGNATURE AND DATE]

Please attach supporting documentation & fax to 503-215-4985