PROVIDENCE HOME MEDICAL EQUIPMENT		**Home Start Adult Tube Feeding Prescription Referral Form**	PROVIDENCE Health & Services
6410 NE Halsey, Suite 500 Portland, OR 97213 Phone: (503) 215-4663 Fax: (503) 215-4011	**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**

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: _____

Diet Order: NPO or _____

☐ Orders per Physician: _____

Does the pt. have a potential for refeeding syndrome? ☐ **Yes** ☐ **No** ☐ **Needs Assessment**

1. **If yes**, order a NUTRITION PANEL (including CMP, phosphorus, magnesium, CBC) every three days after initiation of the tube feeding until goal rate is achieved. *OR* 2. **If patient has Home Health**, RN to draw NUTRITION PANEL (including CMP, phosphorus, magnesium, and CBC) every three days after initiation of tube feeding until goal rate is achieved.

☐ **Tube Placement/Formula Administration.** Orders include:

1. Registered Dietitian to assess nutrition status and write tube feeding orders.
2. Registered Dietitian to instruct on tube site care and tube feeding administration
3. If patient has Home Health, RN to instruct on tube site care and TF administration.
4. If DMAP insurance, RN home visit to evaluate appropriateness of home setting and instruct on tube feeding.

☐ **Tube Placement Only/No Formula.** Orders include:

1. Registered Dietitian (or HH RN, if applicable) to instruct on site care.
2. Registered Dietitian to assess nutrition status and write tube feeding orders in the future when oral intake declines.
3. Registered Dietitian (or HHRN, if applicable) to instruct on tube feeding administration when TF initiated.
4. If DMAP insurance, RN home visit to evaluate appropriateness of home setting and instruct on tube feeding.

Comments:

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

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