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CONTINUUM CONNECT ENTERAL NUTRITION ORDER FORM

****Please attach face sheet w/ patient demographics & insurance info****
****Please attach lab work, clinical notes and/or any other relevant documentation****

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____ Gender: Male Female
 Language Pref.: English Spanish Other: _____ Patient cannot accept deliveries on the following days?
 Height: _____ Weight: _____ Mon Tues Wed Thurs Fri Sat

DIAGNOSIS

Primary Diagnosis ICD-10 Code: _____ **Secondary Diagnosis** ICD-10 Code: _____

NG TUBE:

DISPENSE

Type: _____ French Size: _____ in.
 Tape: 1" 2" 3"
 Medipore: Plastic (waterproof) Cloth (waterproof) Paper
 Duoderm 2" 4"
 Split Gauze
 PH Strips
 Other

GT REPLACEMENT:

DISPENSE

Type: _____ Size: _____
 Extension Sets

METHOD:

DISPENSE

Bolus feeds by feeding pump _____ cc every _____ hour(s)
 Continuous feeds _____ cc every _____ hour(s)
 Dispense feeding pumps, bags and IV Pole
 Bolus feeds by gravity _____ cc every _____ hour(s)
 60 CC Syringes Cath-tipped Luerlock
 Syringes _____ cc _____ per month
 Flush: After feeds or meds. Syringe Bag _____ cc

FORMULA:

Type: _____
 Additives: _____

Order Date: ____/____/____ **Length of Need:** _____ months

REFERRAL INFORMATION

Ref #: _____

Practice Name: _____ Fax: _____
 Office Address: _____ Email: _____
 Phone: _____ Preferred Method of Contact? Phone Fax Email
 Contact Person: _____

Physician Name: _____ NPI#: _____ Phone: (____) _____ - _____ Ext. _____

Physician Signature: _____ Date: ____/____/____

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Assignment of Benefits: I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.

Patient Signature: _____ Date: ____/____/____