PHONE: 1.800.344.1550 FAX: 1.844.317.9379
EMAIL: orders@chcsolutions.com

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?
Mon Tues Wed Thurs Fri Sat

Height: ______________ Weight: ______________

DIAGNOSIS

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

NG TUBE:		DISPENSE
☐ Type: ______________ French	Size: ________in.	
☐ Tape: / Medipore:	☐ 1” ☐ 2” ☐ 3” / ☐ Plastic (waterproof) ☐ Cloth (waterproof) ☐ Paper / ☐ 2” ☐ 4”	
☐ Duoderm		
☐ 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: ______ /______ /________

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