HOME ENTERAL NUTRITION (EN) Order Form

PHONE 515.225.2930 | **FAX** 515.559.2495

Rx Order: Hy-Vee Health to provide Home Enteral Nutrition EN Therapy (Tube Feeding)

Date: _____

Patient Information

Patient Name: _____

Phone: _____ **Sex:** ☐ Male ☐ Female **DOB:** _____

Weight: _____ ☐ lbs. ☐ kg **Height:** _____

Patient's PCP: _____

Feeding Tube

- ☐ NG
- ☐ PEG/G-Tube
- ☐ J-Tube
- ☐ GJ Tube

Documentation Required

Patient is ☐ **ABLE** ☐ **UNABLE** to take foods and liquids by mouth safely and adequately

Condition that prevents oral intake or absorption/indication for EN therapy:

NOTE: Must provide clinical documentation to support patient's condition. May include but not limited to: H&P, RD notes, diagnostic report, swallow study, etc.

Length of Need Statement (LON)

MUST be included in a progress note and signed by the physician

Example of LON: "Due to patient's (condition), tube feeding will be needed (insert amount of time here)."

NOTE: Medicare does recognize time frames such as "lifetime" as appropriate.

Disclaimer: Failure to receive appropriate documentation may delay start of therapy and delivery.

En Management – Dietitian consult (check the box)

☐ Checking the box allows the Hy-Vee Health registered dietitian (RD) to conduct a comprehensive nutrition assessment, provide evidence-based, initial EN orders and ongoing adjustments to the enteral plan of care for your patient while admitted to our service. The treating practitioner will subsequently receive faxed orders as notification of any changes, and as appropriate, will require signature.

Home Health – *In most cases, home health will complete tube feeding instruction.*

Does patient have home health set up? ☐ Yes ☐ No If yes, indicate home health agency: _____

Does Hy-Vee Health need to arrange home health? ☐ Yes ☐ No

Lab Orders – *Not required for all referrals.*

☐ Home health to draw labs ☐ No labs needed monthly

☐ CBC ☐ CMP ☐ Other: CRP and Prealbumin

Hy-Vee Health dietitian to review labs: ☐ Yes ☐ No

Other order: _____

DO NOT COMPLETE THE BELOW SECTION IF DIETITAN CONSULT HAS BEEN ORDERED.

Enteral Formula: _____ Formula substitutions allowed: ☐ Yes ☐ No

Enteral Bolus Order

Cans per feeding: _____

Feedings per day: _____

Total cans per day: _____

Water flushes to total: _____ mL/day

Enteral Gravity Order

Cans per feeding: _____

Feedings per day: _____

Total cans per day: _____

Water flushes to total: _____ mL/day

Enteral Pump Order

Rate: _____ mL/hour

for: _____ hours/day

Water flushes to total: _____ mL/day

Modular: _____ Dose/Instruction: _____

Treating Practitioner Information (i.e., Physician, NP or PA)

Contact Person: _____ **Phone:** _____ **Fax:** _____

Treating Practitioner Printed Name: _____

Treating Practitioner Signature: _____

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