SG Homecare
Raising the standard of care.

ENTERAL ORDER FORM

PHONE: 949.474.2050 FAX: 949.474.4460

PATIENT DEMOGRAPHICS

Patient Name:_____ **DOB**:_____ **Gender:** _____M _____F **Weight:** _____
Phone:_____ **Cell:**_____
Mailing Address: _____
City:_____ **Zip:** _____
Insurance:_____ **Policy ID**: _____
Diagnosis (ICD 10) : _____
Length of Need: _____

FORMULA

☐ **FORMULA:** _____ OR EQUIVALENT FORMULA ☐No substitutions
- ☐ **Volume (only select mL or # of cans):** _____ mL per hour **OR** _____ cans per day
- ☐ **Duration :** _____ **ml/hr over** ___ **hours** **SELECT ONE:** ____ **continuous** ____**intermittent**

ORDERS

☐ **ROUTE:** ☐G-tube (B4087) ☐Low Profile G-Tube (B4088) ☐NG-tube w/ stylet (B4081) ☐NG-tube w/out stylet (B4082)
- ☐ Tube Size: _____ FR _____CM
- ☐ G tube specification: ☐Enfit ☐Mickey ☐Mickey- Mini
- ☐ Reference Number for tube: _____

☐ **METHOD**

☐ **SYRINGE BOLUS**
- ☐ SYRINGE, 30/MNTH (B4034)
- ☐ Enfit (twist in) OR ☐ Straight Cath Tip
- ☐ Reference # _____

☐ **GRAVITY**
- ☐GRAVITY BAG, 30/MNTH (B4036)
- ☐IV POLE (E0776)

☐**PUMP**
- ☐RATE ____ ML/HR
- ☐IV POLE (E0776)
- ☐PUMP BAG, 30/MNTH (B4035)
- ☐PUMP (B9002)

☐**ORAL**

FEEDING TUBE SUPPLY REPLACEMENT(BASED ON MEDICARE/MEDI-CAL GUIDELINES)

EXTENSION SETS (B9998)
☐ CONTINUOUS (RIGHT ANGLE) ☐ BOLUS (RIGHT) LENGTH: ☐ 12” ☐24”

- ☐ **FEEDING BAGS (B4035)**
- ☐ **GRAVITY BAGS (B4036)**
- ☐ **FLUSH SET BAG (B4035)**
- ☐ **EXTENSION SETS (B9998)**
- ☐ **SYRINGES (B4034)**
- ☐ **GAUZE (A6402)**
- ☐**OTHER:** _____

Physician Name:_____ **NPI**:_____
Phone:_____ **Fax:**_____
Physician Signature:_____ **Date**: _____