



functional formularies®

let food be thy medicine

NOTE:

**THIS ENT FORM IS NOT CONSIDERED A PRESCRIPTION (RX).
ALL PRESCRIPTIONS ARE SEPARATE**

ENTERAL NUTRITION INFORMATION

FOR: _____
(PATIENT NAME)

Use (Y) for Yes, (N) for No or (D) for Does Not Apply unless otherwise noted:

_____ 1. Is Enteral nutrition the only source of nutritional intake which the patient can consume/ingest?

_____ 2. Does the patient require Enteral feedings to provide sufficient nutrients to maintain weight and strength to commensurate with the patient's overall health status?

Please circle and/or write the answers to questions 3 - 5.

3.Route of administration for enteral nutrition:

- 1-Gastrostomy Tube
- 2-Jejunostomy Tube
- 3-Nasogastric Tube
- 4-Other _____

4.Please indicate the prescribed calories per day _____ or _____ (ounces/day) , other:

5.Method of administration of the enteral nutrition is (circle all that apply)

- 1 - Syringe (B4034)
- 2 - Pump (B4035)
- 3 - Gravity (B4036)
- 4 - Other _____

6. Formula Ordered:

Quantities will be provided in daily and/or monthly unit increments, where 1 unit = 100 calories. MEDICAL RECORDS ARE REQUIRED FOR INSURANCE COVERAGE **

Form completed by: _____ Title: _____

Signature: _____ Date: _____