ARVADA PHARMACY
MEDICAL SUPPLY

10382 Ralston Road
Arvada, CO 80004
(720) 707-2444 – Phone
(720) 707-2400 – Fax

PHYSICIAN PRESCRIPTION FORM – ORAL & ENTERAL NUTRITION

Please circle YES or NO to all supply.

Patient : _____ **DOB** _____

Address : _____ **Phone** _____

Diagnosis Code : X _____

Length of Need: [12] Months [ ] Lifetime [X] Renewal

Yes No Supplemental Nutrition

Yes No Oral Administration

Yes No Enteral Feeding Tube Administration

Yes No Sole Source of Nutrition

Please List Recommended Formula: **BOOST BREEZE**

Calories per day: _____

Enteral Equipment & Supplies			**Quantity**
Yes	**No**	**Feeding Kit**	_____
Yes	**No**	**Feeding Syringes**	_____
Yes	**No**	**G-Tube**	_____
Yes	**No**	**Extension Set**	_____
Yes	**No**	**Gauze**	_____
Yes	**No**	**Other Items:** _____	

DOCTOR'S NOTES: _____

I, the undersigned, certify that the above prescribed equipment and/or supplies are reasonable and medically necessary as part of treatment for this patient. The need and medical necessity for the above listed equipment and/or supplies are documented in the patient's medical record and available upon request.

Physician's Signature : X _____ **Date** X _____

Physician's Name : _____ **NPI** _____ **Colorado License #** _____

Physician's Address : _____ **Phone** _____