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: Glutasolve

Calories per day: ____________

Enteral Equipment & Supplies **Quantity**

			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** ____________