



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* Arginaid

Please List Recommended Formula: _____

Calories per day: _____

<u>Enteral Equipment & Supplies</u>			<u>Quantity</u>
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 _____