PARAGON HEALTHCARE

ENTERAL THERAPY ORDER FORM

Phone: 866.972.5888 | Fax: 866.491.5888

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Address: _____ Patient SSN: _____

City: _____ State: _____ Zip: _____ Phone: _____

☐ *Demographics Attached*

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

Patient's diagnosis that prevents oral ingestion or absorption: _____

_____

Patient Weight: _____ lbs. Height: _____ Diabetic ☐ Yes ☐ No

Allergies: _____

ACCESS: ☐ Nasogastric ☐ Gastrostomy ☐ Jejunal ☐ Skin level G-tube Size: _____ Fr _____ cm

GOAL OF THERAPY: ☐ Maintain weight ☐ Achieve target weight of: _____

☐ *Labs Attached* ☐ *History Attached* ☐ *Nutrition Evaluation Attached* ☐ *Swallow Study Attached*

ORDERS

☐ RD from Paragon Healthcare to perform nutrition assessment and make formula rate recommendation.

☐ Enteral Formula: _____ Length of Need: _____

☐ Bolus: _____ ml, _____ times per day to total _____ ml per day.

☐ Gravity: _____ ml over _____ hours _____ times per day to total _____ ml per day.

☐ Continuous rate of _____ ml/hour, _____ hours per day to total _____ ml per day.

☐ Home Health for instruction on tube feeding and site care:

Flushes: ☐ _____ ml before and after medications

☐ _____ ml before and after each feeding to total: _____ ml per day

☐ _____ ml, _____ times per day to total: _____ ml per day

Residuals: Patient/caregiver to check residuals

☐ every _____ hours and hold if greater than: _____ ml.

☐ before each feeding and hold feeding if greater than: _____ ml.

Supplies: _____

Special Instructions: _____

_____

_____

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

☐ Dispense as Written ☐ Substitution Allowed

Physician Signature: _____ Date: _____

Physician Name: _____

NPI: _____ DEA: _____ License: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Contact Person: _____