PHYSICIAN'S ORDER FOR ENTERAL NUTRITION

Colonial medical supplies
614 E Altamonte Dr
Altamonte Springs, FL 32701
Phone: 407-849-6455
Fax: 407-849-6458

EFFECTIVE DATE: ___/___/_____

Patient Information:

Name: _____

Phone: (____) _____ **DOB:** _____

HT: _____ **WT:** _____

Physician Information:

Name: _____

Phone: (_____) _____ **Fax:** (____) _____

NPI: _____

DIAGNOSIS INFORMATION

Primary Diagnoses: _____

Secondary Diagnoses: _____

Length of need: _____ **Months**

Prognosis: ____ **Good** ____ **Fair** ____ **Poor**

Method of Administration: ❒ Syringe ❒ Gravity ❒ Pump # of Refills:_____

Enteral

Formula 1:_____ Rate:_____ Quantity:_____ per/day

Formula 2:_____ Rate:_____ Quantity:_____ per/day

Instructions: Store at room temperature.

Additional Information:

Syringe Feeding Kits

❒ B4034 – _____Quantity Per Month

Pump Feeding Kits

❒ B4035 – _____Quantity Per Month

Gravity Feeding Kits

❒ B4036 – _____Quantity Per Month

Enteral Feeding Pump

❒ B9002 – QTY 1 - Required due to _____

❒ E0776 – Invacare Standard IV Stand – QTY 1

Other Supplies

_____ QTY:_____ _____ QTY:_____

Statement of Medical Neccesity: Enteral nutrition required to provide sufficient nutrients to maintain weight and strength commensurate with the patients overall health status.

By signing below I assert I am the treating physician for this patient and this patient meets all of the criteria to qualify for Medicare Coverage for this item. Additionally, I understand:

- Supplier-produced records, even if signed by the ordering physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.
- Templates and forms, including CMS Certificates of Medical Necessity, are subject to corroboration with information in the medical record.

****Corroborating medical records attached**** **Physician Signature:**_____ **Date:**_____