

Physician's Written Order

Enteral Nutrition

To request free samples for your patient, please visit katefarms.com/samples. Kate Farms Customer Care can help your patient navigate the insurance process and connect them with an in-network home medical supplier.

PATIENT

First	MI	Last	
DOB	Gender	Height	Weight
Street	City	State	Zip
Phone	Email		
Caregiver Contact	Phone	Email	Relationship

INSURANCE

Primary Insurance Policy Holder Name	DOB	Secondary Insurance Policy Holder Name	DOB
Primary Insurance	Phone	Secondary Insurance	Phone
Policy/ID	Group #	Policy/ID	Group #
Patient's Current Home Medical Supplier			

PRESCRIBING PHYSICIAN

First	MI	Last	
Street	City	State	Zip
Phone	Fax	NPI#	

DIAGNOSIS

Start Date: ____ / ____ / ____ Estimated Length of Need: _____ months (99 = lifetime)

ICD-10 Diagnosis Code: _____

1. If enteral nutrition is being routed for administration via tube, please indicate the route:

Gastrostomy Tube Jejunostomy Tube Nasogastric Tube Other _____

2. Quantity to Dispense **PER DAY**: _____ mL Carton Calories

3. Please indicate feeding plan (amount and frequency): _____

4. Method of administration of the enteral nutrition is (check all that apply):

Syringe Pump Gravity Oral

5. Formula type/s used to fill order: **DISPENSE AS WRITTEN, NO SUBSTITUTIONS.**

Kate Farms Pediatric Standard 1.2 Vanilla / Chocolate (B4160) Kate Farms Standard 1.0 Vanilla / Chocolate / Plain (B4150) Kate Farms Peptide 1.0 Vanilla / Plain (B4153)
 Kate Farms Pediatric Peptide 1.0 Vanilla (B4161) Kate Farms Standard 1.4 Vanilla / Chocolate/ Plain (B4150) Kate Farms Peptide 1.5 Vanilla / Plain (B4153)
 Kate Farms Pediatric Peptide 1.5 Vanilla / Plain (B4161) Kate Farms Glucose Support 1.2 Vanilla (B4154) Kate Farms Renal Support 1.8 Vanilla (B4154)

Medical records may be required for insurance coverage. Please send this form, insurance cards and appropriate clinical documentation to the medical supply company

I certify that I am the physician/practitioner identified on this form and I have reviewed the Physicians Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. I certify I am qualified, under CMS guidelines, to sign and prescribe medical equipment and supplies. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this Written Order. To the extent that I provide any information to Kate Farms relating to the patient above, I certify that I have received the proper consent from the patient, will provide a copy to Kate Farms upon request, and will indemnify Kate Farms.

Physician/Practitioner Signature: _____ Date: _____
(Stamps are not acceptable)

Printed Name: _____

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