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: _____