Fax form to **805.832.6119** to order Kate Farms for your patient.

Physician's Written Order

Enteral Nutrition

PATIENT

First ______ MI ______ Last ______

DOB ______ Gender ______

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 # ______

PRESCRIBING PHYSICIAN

First ______ MI ______ Last ______

Street ______ City ______ State ______ Zip ______

Phone ______ Fax ______ NPI# ______

DIAGNOSIS

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

Height: ___________________________ **Weight:** ___________________________ **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. **Prescribed calories per day**: ________________ or ________________ *(ounces/day)*
3. Method of administration of the enteral nutrition is *(check all that apply)*:
   ☐ **Syringe** ☐ **Pump** ☐ **Gravity** ☐ **Oral**
4. Formula type/s used to fill order:
   ☐ Kate Farms® **Pediatric Peptide 1.5** *Vanilla* **(B4161)**
   ☐ Kate Farms® **Peptide 1.5** *Plain* **(B4153)**
   ☐ Kate Farms® **Standard 1.0** *Vanilla* **(B4150)**
   ☐ Kate Farms® **Standard 1.0** *Chocolate* **(B4150)**
5. **Quantity to Dispense**: _________________ **Frequency of Use**: ________________________
   Quantities will be provided in daily and/or only unit increments, where 1 unit = 100 calories

Medical records may be required for insurance coverage

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. The patient's record supporting documentation that substantiates the utilization and medical necessity of the products listed and physical notes and other supporting documentation will be provided to Kate Farms upon request. I understand falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

Physician/Practitioner Signature: ____ Date: ______________________

(Stamps are not acceptable)

Printed Name: ____

This fax message and any attachments may contain confidential information. If you are not the intended recipient and have received this message in error, please inform sender and delete the contents without copying, distributing or forwarding. By faxing this form, you are acknowledging that the patient is aware that a Kate Farms representative and/or authorized distributor may be contacting them for any additional information to process this order. Thank you.