



# Physician's Written Order Enteral Nutrition

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

## 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: \_\_\_\_\_

- If enteral nutrition is being routed for administration via tube, please indicate the route:  
 Gastrostomy Tube     Jejunostomy Tube     Nasogastric Tube     Other \_\_\_\_\_
- Prescribed calories per day: \_\_\_\_\_ or \_\_\_\_\_ (ounces/day)
- Method of administration of the enteral nutrition is (check all that apply):  
 Syringe     Pump     Gravity     Oral
- Formula type/s used to fill order:  
 Kate Farms® Pediatric Peptide 1.5 Vanilla (B4161)                       Kate Farms® Peptide 1.5 Plain (B4153)  
 Kate Farms® Pediatric Standard 1.2 Vanilla (B4160)                       Kate Farms® Standard 1.0 Vanilla (B4150)  
 Kate Farms® Standard 1.0 Chocolate (B4150)
- 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.