Coram®
CVS specialty™ infusion services

Tube Feeding Care Program

1. Complete the order form below.
2. Fax your orders to Coram's Nutrition Department at 800.693.7322
3. Call Coram at 888.334.7978 to notify your nutrition team of the order information and fax request being sent.

Referral by ______ Referral Date ______ Start Date ______
Contact Name/Institution ______
Phone/Pager ______ Fax ______

Patient Information

Patient Name ______ Home Phone ______ Work Phone ______
Delivery Address ______ City ______ Zip ______
Billing Address ______ City ______ Zip ______
DOB ______ Male Female SSN ______ Ht ______ Wt ______
Emergency Contact ______ Relationship ______ Phone ______
Primary Dx/ICD-10 Code ______ Secondary Dx/ICD-10 Code ______

Insurance Information

Primary Insurance ______ Policy # ______ Group # ______
Secondary Insurance ______ Policy # ______ Group # ______
Policy Holder ______ DOB ______ Relationship ______

Order / Rx

Formula(s) ______ Or equivalent formula No substitutions
Total volume/day ______ ml Rate ______ ml/hr for ______ hrs **OR** ______ cans/day, ______ days/wk, ______ calories/day
Total Free Water ______ Flush before administration ______ ml Flush after administration ______ ml
Administration supplies as required: YES NO
Diabetic: YES NO Allergies ______ Length of need: ______
Home Health Agency ______ Phone ______
☐ Other/DME ______

Administration Method

☐ Pump Feeding tube supplied: YES NO
☐ Gravity Tube type: NG ______ GT ______ JT ______
☐ Syringe/Bolus Naso tube (B4082) ______ Fr ______ Cm ______ Stylet ______ Wt
☐ Oral G-tube (balloon B4087) ______ Fr Low profile (B4088) size ______ Fr ______ cm

Coram dietitian consult for formula recommendations? YES NO

Referring MD ______ Address ______
Phone ______ Fax ______ License # ______ NPI # ______
Phone orders received from ______ Date/Time ______
I hereby certify that the above services are medically necessary and are authorized by me. The patient is under my care and is in need of the services listed.
MD Signature ______ Date ______

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