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Twinsburg, OH 44087
p 1-800-321-0591 **f** 1-330-963-6172
w www.edgepark.com

Physician's Written Order
Enteral Nutrition & Supplies

All fields are required to process an order.

edgepark® Medical Supplies

Start Date ______ / ________ / ________

patient

First: ________________________ **Last** __________________________ **MI** ________ **Patient DOB:** _____/_____/_____ **Gender** ☐ **M** ☐ **F**
Address: ____ **Phone #:** ____
City: ________________________________ **State:** ____ **ZIP:** ___________ **E-mail Address:** ________________________________

doctor

Prescribing Physician Name: ______________________
Street Address: ________________________________
City: ____________ **State:** ____ **Zip:** ________________
Phone: _________________ **Fax:** _________________
NPI #: ____

insurance

Primary Insurance: ______________________________
Policy/ID #: ______________________________
Group #: ______________________________
Phone #: ______________________________

Secondary Insurance: ______________________________
Policy/ID #: ______________________________
Group #: ______________________________
Phone #: ______________________________

diagnosis

ICD-9/ICD-10 Description

☐ V44.1/Z93.1 Gastrostomy
☐ 560.9/K56.60 Intestinal Obstruction, Unspecified
☐ 783.21/R63.4 Abnormal Loss of Weight
☐ 783.41/R62.51 Failure to Thrive/Gain Weight (Pediatric)
☐ _________ ______________________

ITEM #	PRODUCT DESCRIPTION	QTY

Estimated Length of need: ____ **months** (99 = Lifetime)

*****FOR MEDICARE PATIENTS, PLEASE INCLUDE MEDICAL RECORDS*****

Use Y for Yes, N for No or D for Does Not Apply unless otherwise noted:

_______ 1. Does the patient receive more than ½ of their daily caloric intake through Enteral Nutrition?

_______ 2. Is Enteral nutrition the only source of nutritional intake which the patient can consume/ingest?

_______ 3. Does the patient require Enteral feedings to provide sufficient nutrients to maintain weight and strength to commensurate with the patient's overall health status?

_______ 4. If Enteral Nutrition is being routed for administration via a tube, please indicate the route: Everything orally fed.

1- Gastrostomy Tube 2- Jejunostomy Tube 3- Nasogastric Tube 4- Other ____________________

_______ 5. Please indicate the prescribed calories per day? __________ per day

Does the number of prescribed calories average between 20/35 cal/kg/day? If no, please indicate medical reason.

____

_______ 6. Days per week administered? (Enter 1 — 7) Formulated to be administered 7 day units unless otherwise noted.

_______ 7. Please indicate if the patient has a documented allergy or intolerance to semi-synthetic nutrients?

I certify that I am the physician identified on this form. I have reviewed the Physician's 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 contains supporting documentation that substantiates the utilization and medical necessity of the products listed and physician notes and other supporting documentation will be provided to Edgepark upon request. I understand any 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 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 an Edgepark Representative may be contacting them for any additional information to process this order. Thank you.