Total Home Health
RESPIRATORY & MEDICAL EQUIPMENT
2100 Landmeier Rd | Elk Grove Village, IL 60007
PHONE: 800-834-4234 | FAX 847-931-7138

Written Order Prior to Delivery
ENTERAL

Patient Name	Insurance ID/Group
Address	Insurance Name Insurance Phone
Phone	Order Date
DOB	Height/Weight
Estimated Length of Need _____ (i.e. 99=lifetime)	ICD-10

Name of Enteral Formula: _____ ☐ May substitute

Frequency	**Method of Administration**	**Route of Administration**
Daily: ☐ Yes ☐ No* *If no, select days: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	☐ Bolus ☐ Gravity ☐ Pump	☐ G-Tube Size: _____ FR _____ cm ☐ J-Tube Size: _____ FR _____ cm

Dosage (*select one*)
☐ # cans/day or mL/cc per day: _____
☐ Pump Rate: _____ mL for _____ hrs/day = Total _____ mL/day
☐ Bolus/Gravity: _____ cans at breakfast, _____ cans at lunch, _____ cans at dinner = Total _____ cans/day

Narrative Description of all items provided
☐ Enteral feeding pump, B9002, qty 1
☐ Enteral feeding pump bags, B4035, 30/month
☐ IV Pole, E0776, qty 1
☐ Enteral gravity feeding bags, B4036, 30/month
☐ Bolus feeding kits, B4034, 30/month
☐ Enteral/irrigation 60cc Cath tip, A4213, 4/month

Please attach the following:
- Progress notes/face to face evaluation indicating patient need for prescribed equipment/nutrition
- Test results
- Patient demographics sheet

In my opinion, the supplies ordered are both reasonable and necessary for the treatment of this patient's condition per accepted standards of medical practice and are not prescribed for convenience. My signature below certifies the medical need for these items for this patient. This form must be SIGNED and DATED by the prescribing Physician prior to dispensing supplies and medical equipment.

Physician Name		Physician NPI	
Physician Address		Physician Phone	
Physician Signature	No stamps please – not valid by law	Date	