functional formularies®
LET FOOD BE THY MEDICINE

NOTE:
THIS ENT FORM IS NOT CONSIDERED A PRESCRIPTION (RX).
ALL PRESCRIPTIONS ARE SEPARATE

ENTERAL NUTRITION INFORMATION

FOR: _____
(PATIENT NAME)

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

_____**1.** Is Enteral nutrition the only source of nutritional intake which the patient can consume/ingest?

_____**2.** Does the patient require Enteral feedings to provide sufficient nutrients to maintain weight and strength to commensurate with the patient's overall health status?

Please circle and/or write the answers to questions 3 - 5.

3.Route of administration for enteral nutrition:
1-Gastrostomy Tube
2-Jejunostomy Tube
3-Nasogastric Tube
4-Other _____

4.Please indicate the prescribed calories per day _____ or

_____(ounces/day), other:

_____

_____

_____

_____

5.Method of administration of the enteral nutrition is (circle all that apply)
1 - Syringe (B4034)
2 - Pump (B4035)
3 - Gravity (B4036)
4 - Other _____

6.Formula Ordered:

_____

Quantities will be provided in daily and/or monthly unit increments, where 1 unit = 100 calories. MEDICAL RECORDS ARE REQUIRED FOR INSURANCE COVERAGE **

Form completed by: _____Title:_____

Signature: _____Date:_____