

Date Required: _____ Ship To: Home Office Other: _____

PATIENT INFORMATION

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Cell Phone: _____
 Alternate Phone: _____
 Date of Birth: _____
 Email: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____
 Fax: _____
 DEA #: _____ NPI #: _____
 Contact Person: _____
 Email: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
 Secondary Insurance: _____ ID: _____ Group: _____
 Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

Malabsorption Malnutrition
 Detailed History, TPN orders, Nutrition Consultation/Assessment
 Diagnostic Reports (Operation Reports, CT Scan & Fistulagram)
 Weight Changes: _____

Patient demographics, including insurance information
 Labs – (CMP, CBC with diff, TG, Prealbumin, Mg, Phos, CRP)
 H&P and MD consults
 Please attach original prescription orders

PN DIAGNOSIS

K56.60 Bowel Obstruction
 K95 Complications of Bariatric Procedures
 K50 Crohn's Disease
 K63.2 Enterocutaneous Fistula
 K31.84 Gastroparesis
 O21.1 Hyperemesis Gravidarum
 K90 Malabsorption
 K86.1 Pancreatitis
 K91.2 Small Bowel Syndrome
 Other: _____

PATIENT EVALUATION

Has patient previously received TPN? Yes No
 Patient Weight: _____ kg lbs Height: _____ cm in
 Allergies: _____
 Delivery Method: Infusion Pump Other: _____
Line Access:
 Hickman Broviac Groshong Port PICC
 Therapy Start Date: _____ Therapy End Date: _____
 Nursing Coordination:
 Pharmacy to coordinate home health
 nursing visit as necessary: Yes No

PRESCRIPTION INFORMATION – Consult InfuCare Rx RD for Nutritional Recommendations

Sodium Chloride: _____ mEq/day	Calcium Gluconate: _____ mEq/day	Amino Acids: _____ grams/day
Sodium Acetate: _____ mEq/day	Multivitamin: MVI Adult: _____ mL/day	Dextrose: _____ grams/day
Sodium Phosphate: _____ mmol/day	Trace Elements-MTE 5 Concentrate: _____ mL/day	Lipids: _____ grams/day
Potassium Chloride: _____ mEq/day	Regular Insulin: _____ units/day	Total Volume: _____ mL/day
Potassium Acetate: _____ mEq/day	Other: _____	Infuse Over: _____ hours/day
Potassium Phosphate: _____ mmol/day		Infuse: _____ days/week
Magnesium Sulfate: _____ mEq/day		Total Calories: _____ Kcal/day

Additional Medications & Supplies

<input type="checkbox"/> Anaphylaxis Kit orders as per protocol	<input type="checkbox"/> Lactated Ringers PRN _____ Quantity/Week	<input type="checkbox"/> Scale
<input type="checkbox"/> Catheter Care Maintenance	<input type="checkbox"/> Hydration Bags PRN _____ Quantity/Week	<input type="checkbox"/> Weekly Dressing Changes
<input type="checkbox"/> Glucometer	<input type="checkbox"/> Ethanol Locks	<input type="checkbox"/> Weekly Blood Work

ADDITIONAL ORDERS

Prescriber Signature: _____ Date: _____ UPIN: _____