PARAGON HEALTHCARE
A Carelon Company

HOME ENTERAL NUTRITION (EN) ORDER FORM

P: 833.824.1400 | **F:** 866.491.5888

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 866.491.5888

Name:	DOB:	Feeding Tube
Phone:	Date:	☐ NG ☐ GJ tube
Sex: ☐ Male ☐ Female	Patient's PCP:	☐ G-tube ☐ J-tube
Weight: ☐ lbs ☐ kg	Height:	

REQUIRED DOCUMENTATION

Condition that prevents oral intake or absorption/indication for EN therapy:

NOTE: Must provide clinical documentation to support patient's condition. May include, but not limited to: H&P, RD notes, diagnostic report, swallow study, etc.

Length of Need Statement (LON)
- ***MUST be included in a progress note and signed by the physician***
- Example of LON: "Due to patient's [condition] tube feeding is needed for [insert amount of time here]"
- Medicare requires patient to have a permanent impairment considered long and indefinite duration

Note: Medicare does recognize time frames such as "lifetime" as appropriate
Disclaimer - failure to receive appropriate documentation may delay start of therapy and delivery

EN MANAGEMENT - DIETITIAN CONSULT (CHECK THE BOX)

☐ Checking the box allows the Paragon Registered Dietition (RD) to conduct a comprehensive nutrition assessment, provide evidence-based, initial EN orders and ongoing adjustments to the enteral plan of care while admitted to our service. The treating provider will subsequently receive faxed orders as notification of any changes, and as appropriate, will require signature.

HOME HEALTH - IN MOST CASES, HOME HEALTH WILL COMPLETE TUBE FEEDING INSTRUCTIONS

Does the patient have home health set up? ☐ Yes ☐ No If yes, indicate home health agency:

Does Paragon need to arrange home? ☐ Yes ☐ No

DO NOT COMPLETE THE SECTION BELOW IF DIETITIAN CONSULT HAS BEEN ORDERED

Enteral Formula:		Formula substitutions allowed ☐ Yes ☐ No
Enteral Bolus Order	**Enteral Gravity Order**	**Enteral Pump Order**
Cans per feeding: _____	Cans per feeding: _____	Rate: _____ mL/hour
Feedings per day: _____	Feedings per day: _____	for _____ hours/day
Total cans per day: _____	Total cans per day: _____	Water flushes to total _____ mL/day
Water flushes to total _____ mL/day	Water flushes to total _____ mL/day	

Modular: _____ Dose/Instruction: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____
Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*