CONTINUUMRX™
Specialty Infusion Services
In Partnership with Major Health Systems

Enteral Detailed Written Orders

Patient Name: _____ Referral date: _____

Date of Birth: _____

To Provide the Following Services:

Medical Necessity: This patient requires 100% of need which is met by the following specialized nutrition;

- ☐ Impact Peptide 1.5 375 cal *B4153*
- ☐ Fibersource HN 300 cal *B4150*
- ☐ Isosource 1.5 375 cal *B4152*
- ☐ Isosource HN 300 cal *B4150*
- ☐ Replete 250 cal B4150
- ☐ Replete w/ Fiber 250 cal *B4150*
- ☐ Nutren 2.0 500 cal *B4152*
- ☐ Nutren 1.5 375 cal *B4152*
- ☐ Diabetisource 300cal *B4154*
- ☐ Glucerna 1.5 356 cal *B4154*
- ☐ Peptamen AF 300 cal *B4153*
- ☐ Peptamen 1.5 375 cal *B4153*
- ☐ Novasource Renal 475 cal *B4154*
- ☐ Peptamen Bariatric 250 cal *B4153*
- ☐ Other: _____

Ok to use equivalent formulary.

Order Information

Primary Diagnosis: _____

Pump Rate: _____ ml/hr for ____ hours
Bolus _____ml_____times a day
Total cans per day _____
Calories per day _____

Total free water _____ Flush before administration _____ ml / Flush after administration _____ ml
Diabetic: ☐ Yes ☐ No Allergies: _____

Home Health Agency: _____ Phone: _____

Administration

- ☐ Pump/IV Pole: (B9002/E0776) Pump Supplies (B4035): Kangaroo e-Pump Joey
- ☐ Gravity/IV Pole (B4036/E0776)
- ☐ Syringe/Bolus (B4034)
  Quantity to be dispensed: 30 per month.

- ☐ Low-Profile Button supplies (B4088)

Tube type: NG G J PEG G-J

Refill: 12 months
Length of Need: 12 months

Nutrition Team consult for formula recommendations? ☐Yes ☐No

Physician signature: _____ Date: _____

Physician name: (Please print) _____

Phone: _____ Fax: _____ License #: _____ NPI #: _____

Phone orders received from: _____ Date/time:_____