Coram®
CVS specialty infusion services

# Enteral Nutrition Referral Fax Cover Sheet

**Date:** _____ **# of pages including cover:** _____ ☐ Focus Care Account ☐ New Patient ☐ Change Order

Hospital/Facility Name _____

City _____ State _____

Referral Contact Person _____ Contact # _____

Prescribing Physician _____ Phone # _____

Following Physician for Tube Feeding or PCP _____

**Patient Name** _____ **DOB** _____ **Estimated discharge date** _____

**Patient Status:** ☐ In-patient ☐ Out-patient

**Initial Delivery to:** ☐ Hospital Rm # _____ ☐ Home Address ☐ Temporary Address

## Please fax:

- ☐ Demographic Sheet
- ☐ History & Physical that discusses diagnoses leading to need for tube feeding.
- ☐ RD Evaluation
- ☐ Any pre-authorization from insurance that you have initiated
- ☐ Prescription

**Enteral Prescription Requirements** Rx

- ☐ Physician signature
- ☐ NPI# or Printed Name
- ☐ Patient's Full Name
- ☐ Order date
- ☐ Formula Name (specify "or formulary equivalent" or "no substitution" after formula name)
- ☐ # of refills
- ☐ Formula dose or cans per day
- ☐ Quantity per refill
- ☐ Method of Administration (Syringe/Bolus, Gravity Bag, Pump specifying rate/hr & duration)
- ☐ Route of Administration (G-tube, J-tube, Oral)

Note: for Medicare patients, verify that prescriber is PECOS enrolled

**NOTE: some commercial insurance and Medicaid plans require authorization be obtained prior to dispensing supplies and formula.**

**Type of tube:** ☐ G ☐ J ☐ GJ ☐ NG ☐ NJ ☐ No Tube: Oral formula referral

French size _____ length/cm _____

**If this is an out-patient referral**

- Do you need a Coram RD assessment for formula recommendations? ☐ Yes ☐ No
- Has feeding tube been placed yet? ☐ Yes ☐ No ☐ If no, anticipated tube placement date: _____

**Additional comments or delivery information**

## Please fax this cover sheet along with ALL the requested information to:

**Enteral Nutrition Center Fax# 800.693.7322**

Would you like a phone call to confirm Coram's receipt of this fax? ☐ Yes ☐ No

If you need to contact our Nutrition Center, please call 888.334.7978

***NOTE: Additional information may be requested based on this specific patient's insurance plan.***

## Medicare referral documentation needs

**Medicare Qualification QUICK CHECK:**

If the answer to any of these 3 questions is "No" then the patient will be informed that Medicare may not pay for tube feeding at home and an alternate source of payment will be pursued (secondary insurance, medicaid, self pay)

☐ Yes ☐ No Is the estimated length of need for tube feeding at home >90 days?

☐ Yes ☐ No Is there documented evidence of inability to swallow food, liquids, and mechanically altered diet or a disease that impairs digestion & absorption necessitating J tube feeds (ex. Pancreatitis, Crohn's, malabsorption)?

☐ Yes ☐ No Is the tube feeding the primary source of nutrition?

**SUPPORTIVE DOCUMENTATION REQUIRED-please attach:**

☐ Notes discussing the estimated length of need for tube feeding as a primary source of nutrition

☐ Progress note written by MD

☐ Swallow studies and speech progress notes illustrating severity of swallowing dysfunction or obstruction

☐ Dietitian's assessment of calorie needs and follow up notes

☐ Calorie count reports if patient is eating some by mouth

☐ Feeding tube placement report if new tube

☐ If patient is on a specialty formula (i.e. diabetic, renal, or peptide formula), provide evidence of a failed trial (documented intolerance) on a standard formula

☐ If patient is prescribed a pump, provide evidence the patient tried and failed another method-bolus or gravity or rationale/evidence/medical reason why the patient would not be able to be bolus or gravity fed at home.