**California Home Medical Equipment**
**Enteral Prescription Form**
**Fax to (650) 931-8928 or Call (650) 357-8550**
**Website: www.chme.org / Email: orders@chme.org**

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**Patient Information (Patient name and attach demographic information)**

Patient's Name:_____ Address: _____
Date of Birth: _____ City: _____
Patient's Phone: _____ State: _____ Zip: _____
Contact Person: _____ Contact #: _____

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**Requested Documents (as pertained)**

□ Insurance □ Dietician & MD Notes □ SLP Swallow Eval
*California Home Medical Equipment will verify insurance eligibility and obtain authorization

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**Enteral – Tube Feeding**

Enteral Feedings due to DX: _____

Length of Need: _____

Feeding Tube: □ Nasogastric □ Nasointestinal □ Gastrostomy □ Jejunostomy

Formula or equivalent: _____ Strength: _____

Administration:
□ Syringe (Bolus) Frequency: _____ mL per feeding: _____
□ Gravity (Bolus)
□ Pump (Continuous/Intermittent) Hours: _____ Daily Total mL: _____

Rate: _____mL/hr Time: _____am/pm _____am/pm

Justification for pump: □ Aspiration Hx □ Nausea & Vomiting
□ Dumping Syndrome □ Chronic Diarrhea
□ Other: _____

Daily Freewater: _____ mL/cc

Special Instructions:

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Physician Name: _____ NPI #: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Contact Person:_____

Physician's Signature: _____ Date: _____

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