CLOCK MEDICAL SUPPLY, INC.
SOLVING PROBLEMS / DELIVERING SOLUTIONS

901 INDUSTRIAL BLVD PO BOX 620 WINFIELD, KS 67156-0620
PHONE: 1-620-221-0550 TOLL FREE: 1-800-362-1314 FAX: 1-620-221-7460

FAX

To:

From:

Fax:

Pages: 2 **(including cover page)**

Phone:

Date: 09/22/2015

RE:

Patient DOB:

ENTERAL FEEDING ORDER

To Whom It May Concern:

Please review the following order and complete the information where the ➡ indicates

Also verify that all the information is correct or make corrections acccordingly.

THANK YOU

Please complete the following:

Patient's height and weight

Is the patient currently on Home Health

Administration of Nutrition / Method of Nutrition

Has a swallowing study been conducted? Please send records

Doctor Notes / Surgical Notes

Enteral is sole nutrition source / permanent condition for feeding tube?

Physician's Signature and the Date

And FAX to 620-221-7460

Thank you for your time and help

HAVE A GREAT DAY!

ENTERAL ORDER

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www.ClockMedical.com
Solving Problems / Delivering Solutions

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Winfield, KS 67156
Phone: 620-221-0550
Toll Free: 800-362-1314
Fax: 620-221-7460

Patient Name: _____

Address: _____

City/ST/Zip: _____

Phone: _____

Start Date: _____ **DOB:** _____

Patient Height: _____ **Weight:** _____ **Update of Order:** _____

Is this patient currently on Home Health? ☐ Yes ☐ No

If yes, Home Health Name: _____

Administration of the Nutrition: ☐ Gastrostomy tube ☐ Nasogastric tube ☐ Jejunostomy tube

Is the enteral nutrition the sole source of nutrition provided? ☐ Yes ☐ No

Does patient have a permanent condition requiring tube feeding? ☐ Yes ☐ No

Method of Administration

☐ Syringe (Bolus) _____ Cans/day

☐ Gravity Bag _____ Amt/day

☐ Pump _____ Rate/hr _____ hrs/day

Pump Justification _____

Items to be dispensed per month:

Name of Formula: _____ Calories per Day _____

Days per week Administered: 7

30 days dispensed for 12 months

Accessories for Enteral Feeding Kit

1 each/day Syringes 1 each/day Feeding Bag 1 box Gloves 2 boxes Trach Sponges

1 roll Tape 4/month Tube Ext

_____ Mic-Key kit _____ Gastronomy Tube

Has a swallowing study been conducted? ☐ Yes ☐ No **IF YES, PLEASE SEND DOCUMENTATION**

Physician Signature: _____ Date: _____

Physician's Name: _____ Fax #: _____