



CLOCK MEDICAL SUPPLY, INC.
SOLVING PROBLEMS / DELIVERING SOLUTIONS

901 INDUSTRIAL BLVD
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WINFIELD, KS 67156-0620
FAX: 1-620-221-7460

FAX

To:

From:

Fax:

Pages: (including cover page)

Phone:

Date:

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 accordingly.

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!

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ENTERAL ORDER



901 Industrial Blvd, PO Box 620
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: _____

30 days dispensed for 12 months

Accessories for Enteral Feeding Kit

_____ Syringes _____ Feeding Bag _____ Gloves _____ Trach Sponges
_____ Tape _____ 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 #: _____