LUX INFUSION

Enteral Order Form

Phone:

Fax:

FAX

To: LUX Infusion **Fax#: 315-802-5780**

From: (Name) (Location) (Phone#)

RE: New Referral Pages:

Patient Name: Date of Birth:

Diagnosis: Medicaid CIN#: Medicaid PA#:

Allergies: Height: Weight:

Access:

Referral Checklist - Please Attach the Following

☐ Demographics ☐ H&P ☐ Progress/Nutritional Notes ☐ Labs ☐ Med Profile

Medication Ordered

Formula: Sig: cans via daily Quantity: ____ can/mth ☐ Refills: 5

Formula: Sig: Quantity: ☐ Refills: 5

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Modality:

☐ Enteral Pump (lifetime)	Qty 1	☐ Refill 1
☐ Pump Supply Kit	Qty 30	☐ Refill x5
☐ Bolus Supply Kit	Qty 30	☐ Refill x5
☐ Gravity Supply Kit	Qty 30	☐ Refill x5

Access:

☐ MK Button	_____ Fr	_____ cm	Qty 1	☐ Refill x1
☐ AMT Button	_____ Fr	_____ cm	Qty 1	☐ Refill x1
☐ NG Tube	_____ Fr	_____ inches	Qty 1	☐ Refill x5
☐ G Tube	_____ Fr		Qty 1	☐ Refill x5

Prescriber Signature: _____ Date: _____

Print Name: _____ NPI#: _____

By signing this form, you, as the following physician are authorizing LUX Infusion to transcribe the above order into verbal orders.

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