Wellscript
An Owens Company

CHICO
Phone: (530) 225-8898 | Fax: (530) 246-7366
REDDING
Phone: (530) 225-8898 | Fax: (530) 246-7366

WELLSCRIPT ENTERAL PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to Wellscript Infusion Pharmacy (530) 246-7366.

Patient Name:	Date of Birth:
Address:	
Phone:	Height: ☐ in ☐ cm
	Weight: ☐ lb ☐ kg

Clinical Information

ICD-10 Code/Diagnosis:

Allergies:

ENTERAL TUBE PLACEMENT STATUS

☐ Tube placed-date: _____ ☐ Tube placement pending-anticipated date: _____

Type of feeding tube placed or anticipated type to be placed:

☐ NG (nasogastric) tube ☐ G-tube (gastrostomy or PEG) ☐ G/J-tube

☐ NJ (nasojejunal) tube ☐ J-tube (jejunostomy or PEJ) ☐ Other: _____

PRESCRIPTION (SELECT ONE OF THE FOLLOWING OPTIONS)

☐ Wellscript Infusion dietitian to assess patient's needs and recommend initial feeding plan, additional free water flushes, and advancement to goal.

☐ Enteral nutrition as follows:

Feeding Method:

☐ Syringe (bolus) ☐ Gravity ☐ Pump

Formula Name: _____

Equivalent formulations may be substituted where clinically appropriate.
Check here if formulation substitution is ***not*** permitted - ☐.

Feeding Plan:

Please indicate amount and frequency.

Additional Free Water Flushes

Please indicate amount and frequency for tube patency and patient hydration.

Anticipated duration of therapy: _____ ☐ months ☐ weeks

Skilled nurse to assess, teach, and train self-administration of enteral feeding to patient and/or caregiver.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

PRESCRIBER INFORMATION

Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State:	Zip:	Office Contact: