

Pharmacy Name: _____ Phone: _____
 Address: _____ Fax: _____
 City/State/Zip: _____ Email: _____

Enteral Referral Form

To	From
Name of Practice/Facility	Phone Fax
Intake Phone	Number of Pages including Cover
Date	Home Phone
Patient Name	Date of Birth
Patient Home Address	City State Zip
Diagnosis	Gender M F
Patient Eating? Y N	Estimated Length of Therapy First Dose? Y N
IV Access PICC Port Central Other: _____	Y N
Hospital Discharge Summary attached? Y N	Most Recent Labs (date) <input type="checkbox"/> Attached
Start of Care Date	Spanish-speaking Only <input type="checkbox"/>
History & Physical <input type="checkbox"/> Attached	Marital Status S M D W Diabetic? Y N
HT WT	Allergies
Other home health care needs?	
Physician signing discharge orders	Fax Phone
Physician who will follow patient at home (if different than above)	
Physician Name	Fax Phone
Patient Demographics <input type="checkbox"/> Attached	Delivery Address (if different than home)
Patient Cell Number	Patient Work Number
Emergency Contact Outside Home	Relationship Phone
Caregiver Name	Caregiver Teachable? Y N Phone
Patient Independent? Y N	Patient Teachable? Y N Homebound? Y N
Insurance ID#	Phone
Issue Date	

Enteral Orders

I authorize Fannin Infusion Pharmacy and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Fannin Infusion Pharmacy. Physician Signature: _____
 Date: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

The attached document(s) contain confidential information which may be considered to be Protected Health Information and therefore required to be maintained as private and secure under HIPAA. The documents may also contain information which is otherwise considered to be privileged under state and federal laws. This communication is for the intended recipient only. If you are not the intended recipient, or a person responsible for delivering this communication to the intended recipient, you are prohibited from viewing, copying and/or distributing the information contained herein. Unlawful disclosure of the information attached may subject you to monetary penalties and sanctions. If you have received this communication in error, you should notify the sender immediately and thereafter permanently destroy all copies of this document in its entirety.

This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.
 This is not a valid prescription in the state of Arizona.
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