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) ■ Attached
Start of Care Date	Spanish-speaking Only ■
History & Physical ■ 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 ■ 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