139 East Main Street
Forest City, NC 28043
Phone: 828-245-9410 Fax: 828-245-5013

____Initial Order ____Refill Order

Name of Patient:_____ Date of Birth:_____

Caregivers Name:_____

Address:_____

Phone Number:_____ Insurance:_____
*we will need a copy of cards before pt can receive product

Medical Information:

Medical Conditions/Dx Codes:_____

Start Date of Therapy:_____ Length of Need:_____

Order information:

Type of Nutrition:_____

Method of Administration: Mouth Syringe Gravity Pump
*If nutrition is being administered by pump: Rate:_____ # of hrs daily:_____

Directions for use:_____
Ex: Give 1 can by mouth 3 times daily

Dispense total # of Cans per Month:_____ Total # of Calories per 24 hours:_____

Supply Kits:
(Quantity dispensed on a monthly basis based on daily need. Please list specific supplies needed.
Supplies may include syringes, feeding bags, gloves, drain sponges, tape, mouth swabs, Pump, IV pole, etc)

____Syringe: #30 60 ml syringes (1 syringe per day)
Other:_____

____Pump: #30 Enteral Nutrition Feeding Bags (1 bag per day) 1200 ml OR 500 ml
Other:_____

____Gravity: #30 Gravity Feeding Bags (1 bag per day)
Other:_____

____Low Profile Gastrostomy Tube (specific tube and frequency):_____
*Medicare allows 1 tube every 3 months *NC Medicaid requires Prior Authorization if more tubes are needed*

____Extension Tubes (QTY and Frequency):_____
*Medicare includes extension tubes in Administration Kits *NC Medicaid allows #2 monthly with a Prior Authorization*

Physician Signature:_____ Date:_____
Physician's NPI:_____

Name of Practice:_____

Practice Address:_____

Phone #:_____ Fax #:_____

***Please fax most recent history and physical to SMITH'S DRUGS (828) 245-5013 along with order. Documentation must justify the need for medical nutrition for the patient's insurance to pay for nutrition and supplies!**