Parenteral Nutrition Prescription/Referral Form

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Ship to: ☐**Patient** ☐**Office** ☐**Other:** **Date need by:**________________________________

Patient Information

Patient Name:____
Address: ____
City,State,Zip:____
Home Phone:____
Alternate Phone:____
SSN#_______-________-_________ Allergies:________________________
Date of Birth:_______________Gender:__________ Weight: ____lbs ____kg

Caregiver Name:________________________ Relationship: Phone:
Emergency Contact:_____________________ Relationship: Phone:

Patient ethnicity:_______________ ☐ See attached demographic sheet

Prescriber Information

Prescriber's Name

State License #:
NPI:
Address

Phone:
Fax:
Contact Person: ____________________

INSURANCE INFORMATION (**Please copy and attach copy of insurance and prescription card**)

Primary Insurance: ___________________
City:________________ State:_________
Plan #: _____________________________
Group #: ____________________________
Phone: _____________________________

Rx Card (PBM): _________________
PBM BIN:_______ PCN: ___________
City: _____________ State:_________
Group#: ________________________
Phone: _________________________

Secondary Insurance:___________________________
City:____________ State:_____________
Plan#:______________________________
Group#:_____________________________
Phone:_____________________________

CLINICAL AND PRESCRIPTION INFORMATION

Diagnosis: ICD 9 __________________________ Sterile Water for Injection: ( ) Total ML: __________

Base Solution:	**Check solution used:**	**Grams:**	**kcal:**	**Total ML:**	**Solution Specifics:**
Amino Acid/Protein (4.0 kcal/g)	( ) 8.5% ( ) 10% ( ) 15%	____ Grams of Protein			Specific AA formulation:
Dextrose/Carbohydrate (3.4 kcal/g)	( ) 30% ( ) 50% ( ) 70%	____ Grams of Dextrose			
Clinimix	Product Used:				
Lipids (1.1 kcal/ml; 2 kcal/ml; 3 kcal/ml)	( ) 10% ( ) 20% ( ) 30%	____Grams of Lipids			Frequency of Lipids:

Electrolytes:	**Dose/Bag:**	**Vial Conc:**	**Vol/Ba**
( ) Calcium Gluconate	___ mEq	___ mEq/ml	___ ml
( ) Magnesium Sulfate	___ mEq	___ mEq/ml	___ ml
( ) Potassium Acetate	___ mEq	___ mEq/ml	___ ml
( ) Potassium Chloride	___ mEq	___ mEq/ml	___ ml
( ) Potassium Phosphate	___ mM	___ mM/ml	___ ml
( ) Sodium Acetate	___ mEq	___ mEq/ml	___ ml
( ) Sodium Chloride	___ mEq	___ mEq/ml	___ ml
( ) Sodium Phosphate	___ mM	___ mM/ml	___ ml
( ) Other:			

Additional Additives:
( ) Ascorbic Acid ___ mg
( ) Famotidine ___ mg
( ) Folic Acid ___ mg
( ) Insulin/Regular ___ units
( ) Multiple Trace Elements ___ml
( ) Multivitamins ___ ml

Prescription Information

Infusion Volume and Rate:
Date of first infusion :____________ Length of Treatment:__________________ Total Vol. _____ ML Administer over: ____ Hours
Rate of Infusion: ________ ML/HR
( )Continuous ( )Cyclic ( )AM ( )PM ( ) No Taper ( )Taper up for____Hr ( )Taper down for ____Hr

Prescriber Signature: ____ Date: ______________

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.

Fax completed form to: (888) 963-8103 Thank you for using BioTek reMEDys!