Option1 Nutrition Fax Order Form

Complete Form Below
Fax order to (866) 453-3332
Call Option 1 at (866) 883-11880 to confirm

OPTION 1 nutrition solutions

Referred by _____ Date _____
Contact Name _____
Phone Number _____ Fax Number _____

Patient Information

Patient Name _____ Home Phone _____Work Phone _____
Delivery Address _____ City _____ Zip _____
Billing Address _____ City _____ Zip _____
DOB _____ ☐Male ☐ Female Ht _____ Wt _____
Emergency Contact _____ Relationship _____ Phone _____
Primary Dx/ICD-9 Code Secondary Dx/ICD-9 Code

Insurance Information

Primary Insurance _____ Policy # _____ Group # _____
Secondary Insurance _____ Policy # _____ Group # _____
Policy Holder _____ DOB _____ Relationship _____

Order / Rx

Formula(s) _____ ☐ Or equivalent formula [ ] No substitutions
Total Volume/day ____ ml Rate ____ml/hr for ____ hrs OR ____ cans/day, _____days/wk, _____ calories / day
Total Free Water _____ Flush before administration ____ml Flush after administration ____ ml
Administration supplies as required: ☐YES ☐ NO
Diabetic: ☐YES ☐NO Allergies _____ Length of need: _____
Home Health Agency _____ Phone _____
☐Other / DME _____

Administration Method

☐Pump	Feeding Tube supplied: ☐YES ☐NO
☐Gravity	Tube type: NG _____ GT _____ JT _____
☐Syringe / Bolus	Naso tube (B4082) _____ Fr _____ Cm _____ Stylet _____ Wt _____
☐Oral	G-tube (balloon B4087) _____ Fr Low profile (B4088) size _____ Fr _____ cm _____

Option 1 dietitian consult for formula recommendations ☐YES ☐ NO

Referring MD _____ Address _____
Phone _____ Fax _____ License # _____ NPI # _____
Phone orders received from _____ Date / Time _____
I hereby certify that the above services are medically necessary and are authorized by me. The patient is under my care and is in need of the services listed.

MD Signature _____ Date _____