Return Signed RX via Fax to 334.279.7032

KabaFusion Enteral Referral Form

To:	From:
Intake Phone: **800.831.7740**	Phone: Fax:
Date:	Number of Pages, Including Cover:
Patient Name:	Home Phone:
Date of Birth:	Name of Clinic:
Patient Home Address:	City: State Zip

Diagnosis:	Gender : Male Female
Type of tube: PEG Low Profile Button PEG/J J-tube	First Dose? Yes No
Patient Eating? Yes No	Estimated Length of therapy:
Faxed copy of Placement: Yes No	Swallow test: Yes No
IV Access: PICC Port Central Other	Pump Required? Yes No
Has Patient been instructed on use of pump: Yes No	Other tests:
Hospital Discharge Summary attached? Yes No	Most Recent Labs (date): Attached:
Formula Name:	Volume per day: Rate:
Anticipated Start of Care Date:	Delivery Due Date:
Start of Care Date:	Spanish-speaking Only
History & Physical Attached	Marital Status: S M D W Diabetic? Yes No
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	Patient Cell Number:	Patient Work Number:
Delivery address (if different than home):		
Emergency Contact Outside Home:	Relationship:	Phone:
Caregiver Name:	Caregiver Teachable? Yes No	Phone:
Patient Independent? Yes No	Homebound? Yes No	Patient Teachable? Yes No
Insurance:	ID#	Phone:
Medi-Cal ID#:	Issue Date:	
Medicare D? Yes No Part D Plan:	ID#:	Phone:
Is Initial Nutrition Assessment to be provided by a KabaFusion Registered Dietitian? Yes No		

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