



**Return Signed RX via Fax to 317.870.2085**

**KabaFusion Enteral Referral Form**

To:		From:							
Intake Phone: <b>317.870.2090</b>		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?									
<b>Physician signing discharge orders:</b>					Fax:	Phone:			
<b>Physician who will follow patient at home (if different than above):</b>									
<b>Physician Name:</b>					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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