



**Return Signed RX via Fax to 734.425.0470**

**KabaFusion Enteral Referral Form**

To:		From:						
Intake Phone: <b>734.425.2550</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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