



**Return Signed RX via Fax to 800.915.3423**

**KabaFusion Enteral Referral Form**

To:		From:			
Intake Phone: <b>800.383.8393</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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